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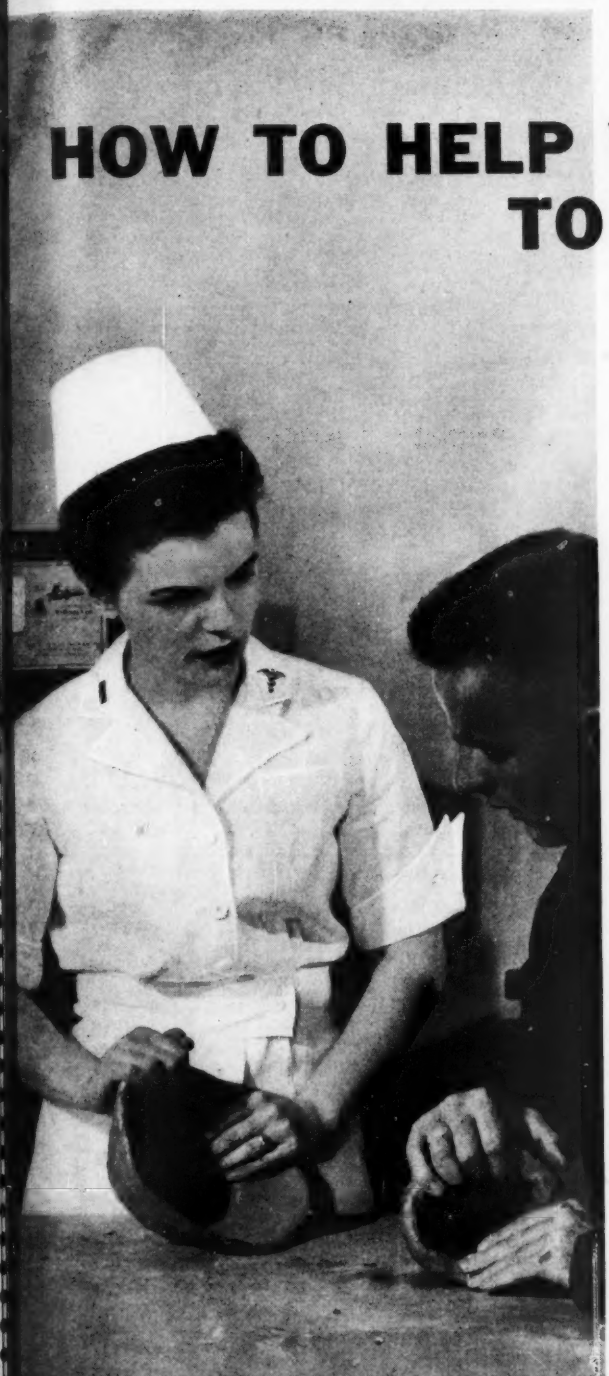

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THE AMERICAN JOURNAL

of

OCCUPATIONAL THERAPY

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January-February 1960 Vol. XIV, No. 1

THE OCCUPATIONAL THERAPIST AS A THERAPIST*

WILLIAM R. CONTE, M.D.†

We are on the verge of a new horizon in occupational therapy. It is evolutionary rather than revolutionary; but be that as it may, there is little question that we are about to emerge on a program which will tend to minimize individual occupational therapy projects and to emphasize the therapist and the interaction between the patient and the therapist. In effect, I am saying that the future of occupational therapy rests in the psychotherapeutic role which the occupational therapist can play with his patient.

To be sure, there are many occupational therapists who are repulsed by the idea that they can be psychotherapists. Many other occupational therapists would deny that they are psychotherapists even though they deal with their patients in a manner which utilizes relationship and transference phenomena. I am sorry to report, also, that some others, particularly zealous in their possessiveness of patients, do not like this concept. The "team approach" in psychiatric treatment, however, has clearly shown that therapeutic relationships may profitably be established and utilized by many. Our hope in occupational therapy is the effective understanding and efficient utilization of the psychotherapeutic role in dealing with our patients.

In looking at this new hope in the future of occupational therapy, I feel impelled to review some historical developments.[1] It is common knowledge that occupational therapy in the beginning was a time-filling endeavor for sick people. Closely allied with this has always been the hope that the occupational therapy project might have a specific therapeutic effect. Sidney Licht quotes Mr. Barton, a representative of the Society for the Promotion of Occupational Therapy, who in 1917 said, "The first thing that is to be done . . . is for occupational therapy to provide an occupation which would produce a semi-therapeutic effect (similar) to that of every drug in materia medica, an exercise for each separate organ, joint and muscle of the human body."[2]

Laurel Nelson, in a far-sighted article written in 1954, reports this same concept. He says: "In the process of professional maturation, some aspects of occupational therapy were able to become more finely differentiated than others. In orthopedics, for example, occupational therapy achieved a high degree of favorable results by the development of various specific treatment methods. The physician, in prescribing occupational therapy for a patient with limited range of motion of a lower extremity, could usually expect improvement in his patient. The occupational therapist, by giving a series of treatments on the weaving loom, bicycle saw, printing press, and with proper positioning, could demonstrate this improvement for daily reporting of changes measured in the joint angle. The results could then be balanced against a constant, the normal range of motion. The evident, the tangible, the specific, were clearly seen when the benefits were evaluated."[3]

While both of these concepts (time-filling and specific therapeutic effect) are historically important in the development of occupational therapy, they have also proven to be stumbling blocks to the general acceptance of occupational therapy in modern times. I am interested to see that in many hospitals today, the primary line of resistance to occupational therapy is that "this is something which *just* gives the patient something to do; we cannot afford this luxury." On the other hand, resistances to occupational therapy are also offered by certain well-trained individuals who feel threatened by the possibility that occupational therapy may provide a specific

*Read at the annual meeting of the Texas OT Association, Waco, Texas, May, 1959.

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curative agent. Here, such an individual is actually admitting that *only* he can treat a patient and, any procedure which has specific therapeutic effects, is something which challenges his unique role with his patient.

In the evolution of things in occupational therapy, some emphasis has been placed on the role of the therapist himself. We do not, however, have to go back to early history for this inasmuch as concern about the role of the therapist is relatively recent. Again, in a review of the literature it is interesting to note what has been said about the therapist. Edward Liss[4] has said, "The problem of the personality of the educator, whether physician, occupational therapist or psychologist, is as important as the patient who is to profit by that contact. I think we need to examine the potentialities for *giving* in our educators . . . "

Evelyn Carrington[5] has said, "Occupational therapy is a personal-relations job. To succeed, the therapist must have, in addition to her vocational training, the characteristics of a good leader; she must see the patient as an individual played on by his many environments; and she must be able to recondition the patient by the use of situational therapy coupled with activity. The therapist should be sensitive to herself and to others, emotionally responsive and intellectually hospitable."

Doctor Robert R. Hewitt, of the United States Public Health Service, was most descriptive of the occupational therapist who deals with psychiatric patients. He said, "The attitude of the therapist should be objective. A person who is inclined to have many complaints should not work with mental patients. Frequently the therapist worries about his own condition and sees in himself the symptoms which appear in the patient."

From these random quotes, I think it is obvious that our concern about the therapist in the past has been more in terms of his being a good leader, or having such aggressive potentials as make it impossible for him to encourage patients to complete their particular assignments in occupational therapy.

In a final historical consideration, I am attracted to the paper by J. Martin Myers, who (in 1951) points out the need for increasing the line of communication between therapists and the doctor so that problems may be solved by conference.[7] To this I say *Amen.*

Thus, in an historical glance, albeit one somewhat slanted toward psychological considerations, we can draw a few conclusions:

(a) Occupational therapy has been viewed as recreational and diversionary, *but this is not enough.*

(b) Occupational therapy has been looked on as providing a specific therapeutic effect, *but this is not enough.*

(c) The need for occupational therapists to be good educators, aggressive and supporting therapists, has been noted, *but this is not enough.*

(d) The need for better communication between therapists and physician has been recognized, *but this is not enough.*

Somewhere, out of this picture, there needed to emerge, and still needs to be clarified, a new recognition of the relationship which exists between the therapist and the patient and on which, in the final analysis, the ultimate effectiveness of occupational therapy must depend.

With the crying need for treatment services in psychiatry today, there has been still another impetus toward evaluation and improvement of occupational therapies. Psychiatrists, for the most part, will admit that they cannot handle all the problems of the psychiatric population by themselves. They must use the ancillary services as a part of the treatment team. Because of this, I feel that occupational therapy is becoming more highly respected. If occupational therapy is to maintain its place in the therapeutic community and is to become a part of the growing medical future, it is my feeling that we must now turn our backs on such ideas as specific therapeutic advantage in the occupational therapy project, as well as to forget the compulsively completed occupational therapy prescription. These ideas tend to remove us from the matter of real relationship to patients. We must look instead to the principles of psychiatric treatment and apply them to occupational therapy in the therapist's relationships to patients. You will understand that I am suggesting that these principles apply to all patients regardless of the diagnosis, severity of illness, duration, etc.

In psychiatry, we emphasize relationships with patients, but this is not an ordinary relationship. It is one which in itself mirrors all previous relationships of that individual patient with his environment. In this relationship the patient comes with hostilities and fears and many mixed emotions. These feelings, of course, are the result of frustrations experienced earlier in life and in relationships to important and influential people he has known.

In his new experience with the occupational therapist the patient brings his particular combination of feelings and he meets the new important and influential people (his therapists) with reactions similar to those he has practiced and perfected through the years. This basic phenomenon opens several vistas to the occupational therapist.

First of all, to do justice to the patient the occupational therapist must recognize that he is not the *real* subject of the patient's dependency demands or his hostile attacks. Rather, he is a substitute for someone else, albeit, perhaps a substitute for a whole series of attitudes directed toward the patient from the beginning of his time. His ability to accept these emotional expressions without shock, fear or disgust will possibly provide the patient with a reaction quite dissimilar to that he has experienced before—and ultimately lead to the establishment of a warm and secure relationship.

A second great concern in this newer understanding of psychotherapy applied to occupational therapy is the personality of the therapist. He, like his patient, comes with a personality which is the result of life's previous experiences. This means that he has hostilities, dependencies, and mixed feelings which will enter into the therapeutic relationship. He, too, comes with certain needs which seek satisfaction; then, too, the therapist's patterns of reaction are established and he responds to hostilities and dependency in others in rather set ways.

This leads me to a third concern. Implicit in psychotherapy is the concept that one of the participants in the relationship is there for help, while the other is there to give help. Lest there be confusion, I would like to point out that the *patient* is the one who is there for treatment. This means that the problems of the therapist, his individual needs seeking satisfaction in the therapeutic relationship, and the often untherapeutic reactions he demonstrates, must be brought under some measure of control. Unfortunately, too few of us are endowed with sufficient maturity to accomplish this alone. For this reason *supervision* administered by our colleagues who can be objective and not subjective, interpretive and not destructive is our hope in the future. The occupational therapy prescription must go, because it serves as a device which keeps us apart. Supervision of the type I have described must come, because it brings us together to work out our own problems.

I can illustrate the need for working through our own problems in a number of other ways. We are talking today, for example, about the advantages of open doors in psychiatric hospitals. I have found that the people who are most upset by the open doors in psychiatric hospitals are the doctors and the nurses and the occupational therapists who find that to work with an unlocked door is a threatening experience. Perhaps in our insecurity in dealing with patients, we would like to have our work hidden behind the locked door. Or maybe because of personal inadequacy we find that we can best control our patients by being sure that they are confined within a certain area.

Precisely the same phenomenon is manifest in the continued use of uniforms by doctors, nurses, occupational therapists, etc. To don the white garb is to disguise one's personality. In a way, we can be more authoritarian and we have less need to use our own personalities in establishing rapport if we can hide behind the cloak of our union.

We talk about therapeutic teams—teams can work only when we can understand our own feelings of prestige and power well enough to be able to give, and give comfortably, in relationship to our patients and to our fellow workers. Unfortunately, we have many fears about such a relationship. There is the concern that we might not do our best and that others might find out about it; or there is even greater concern that someone else may be able to do better than we.

The occupational therapist on any service has fellow team members and patients with whom he must work out suitable relationships. The establishment of workable relationships on both of these levels is dependent upon the therapist's own emotional security and self-understanding. To be a truly effective teammate means to give and take cooperatively. To be a good therapist is to have worked out one's own anxieties to such a degree that he is capable of accepting and understanding his patient. I contend that we find a solution to these personal problems, and that we grow through individual supervision.

The effective therapeutic approach in occupational therapy today and in the future is one in which the therapist utilizes the tools of his trade as an avenue of introduction. From then on his personality takes over. In his relationship to patients he should scrutinize his own concerns over the reactions of his patient. At the same time he must scrutinize some of his own positive feelings toward the patients and try to understand them. The therapist's own feelings of being offended and his own need to defend himself against insecurity are problems which he must handle. Probably a close supervisory relationship with those people who are in a position to provide supervision is our greatest hope.

In the future, as we look to continued growth in occupational therapy, we must seek a closer scrutiny of those individuals who are to provide the occupational therapy services. Individual therapists are not all things to all people; but,

(*Continued on page* 12)

THE FUTURE PATTERN OF OCCUPATIONAL THERAPY

Mosaic or Unity*

JANET ANDERSON, O.T.R.†
EDWARD E. GORDON, M.D.††

Anyone who has the responsibility of recruiting occupational therapists in a general hospital comprising different services, cannot help but be surprised at the proliferation of specialists emerging from the schools. A large majority of graduates fresh from schools of occupational therapy come into the field having already made a choice without any experience narrowly limited either to pediatrics, or general medicine and surgery, or orthopedics, or cerebral palsy. While this tendency to focus upon one aspect of practice may reflect the temperament and penchant of the neophyte therapist, it raises the question whether early restriction of interests is not fostered by the training and attitude of the schools themselves. It is, therefore, proposed to examine this question, not from any spirit of depreciation but with the intent of stimulating healthy criticism so essential to the proper growth of any institution.

There are two basic points in the student affiliation program: (1) the lack of synthesis of the various clinical functions of occupational therapy leads to overspecialization; (2) the classification of these functions which, besides being mutually inclusive of one another descriptively, favors fragmentation of the students' conceptual approach to the discipline.

It is general practice of schools to send their students for clinical training in various branches of medicine which are termed "orthopedics," "G M and S," "pediatrics," etc. While these subdivisions may be necessary from a didactic and administrative view to facilitate the placement and progressive education of the student, it is no more than that. This breakdown in clinical practice readily lends itself to compartmentalization. It is never followed by a process of synthesis by which the trainee is encouraged to see the integration of parts into a whole. Rather the breakdown leads him to regard each fragment as an entity unto itself, and consequently the therapist becomes one-sided in his view and proficiency. We shall return to this consideration later.

Worse still is the unfortunate terminology of the various clinical functions of occupational therapy, such as "orthopedics," "G M and S." It is semantically wrong and hence conceptually deficient; in the end it leads to professional confusion. For example, the term "G M and S" sounds dangerously like labeling the functional purpose with a name which originally referred merely to the *location* where that purpose was carried out. The location may be a general hospital or the general medical and surgical wards of such a hospital. By the process of abstraction the term "G M and S" comes eventually to describe the activities practiced only upon those patients requiring what is sometimes referred to as "tonic" therapy. And it is a further extension of this process of abstraction, finally, that results in a double error. One considers that *only patients on G M and S wards* require "tonic OT" and that only "tonic OT" patients comprise the entire population of G M and S wards. General medicine and surgery are never so limited in extent. Along with patients recovering from operations and self-limited acute infections and diseases there are on the same wards cardiacs, hemiplegics, arthritics. These latter require "tonic" treatment, too.

A similar argument applies to the designation "orthopedic." Do we mean patients found on orthopedic wards only, or do we include neurology, neurosurgery, medicine, rheumatology? Obviously we imply the practice of physically directed restorative therapy—in a word, rehabilitation. Again, do not these also require attention to their fears, anxieties, boredom, depression? The interdependence of physical and psychological deviations occurring in disability needs no belaboring.

The point is that G M and S and orthopedic therapy as currently regarded makes an artificial distinction among patients which does not conform to the realities. If we mean by the term "general medicine and surgery" only those with self-limited affections requiring tonic OT, then we should say so. But we should include *all* patients in general medicine and surgery, and so enlarge our concept beyond the limited outlook presently practiced in this area. If we really mean by "orthopedics," disabilities, then we

*From the department of physical medicine, Michael Reese Hospital, Chicago, Illinois.
†Supervisor, occupational therapy.
††Director, department of physical medicine.

should call it that. And if we do so, the implication that only physical ministrations are within its domain immediately becomes untenable, for tonic OT is also of vast importance here. Thus "G M and S" and "orthopedics" as categories are completely invalid; they are mutually inclusive; they are artificially restrictive in meaning; they exclude by arbitrary definition what rightfully falls within their concern; they tend to perpetuate rigid lines of thought and action; and above all, militate against a synthesis of therapeutic aims vital to the restoration of health in its fullest sense.

"Pediatrics" as a descriptive category is likewise subject to criticism. By this term one customarily thinks of those activities designed to allay anxiety, promote cooperation with and adjustment to the hospital staff, encourage socialization, channelize aggressive behavior into constructive activity, evaluate intellectual and emotional development of the child—all those responsibilities commonly assumed by the therapist on the pediatric service. But shouldn't physical restorative techniques also be applied by him? After all, if the therapist has talent for working with children, why should he be limited in "pediatrics" only to the psycho-social concomitants of disease? Furthermore, as pointed out above, the disabled child is also in need of supportive management psychologically. It is against the best interests of a well-rounded experience artificially to divide practice into the restrictive categories of "cerebral palsy," "pediatrics," and the like. This view does violence to the holistic concept of rehabilitation. It is far more sound to regard "pediatrics" in its broad sense and equip the therapist to deal with the entire problem of occupational therapy in the young, as he should in the adult. This approach certainly is in accord with present day principles of total medicine.

If this thesis is acceptable and outworn terminology and procedure of teaching be discarded, the first point raised, viz., integration of the parts into a whole can be easily achieved. A second benefit will automatically accrue—change in emphasis from overspecialization in occupational therapy to a broad and well-rounded professional competency, which fits a therapist to take his place in almost any therapeutic situation.

To this end let us re-examine the basic roles played by a therapist in his work, and attempt to come up with workable descriptive categories consonant with reality and conceptually progressive. Classifications are treacherous devices as they are oversimplified statements often subjectively determined. For our purpose the following outline is only a tool for the discussion and it is not to be taken as an absolute formulation of the aims of occupational therapy. This classification will then lead to a design for a training program in terms of holistic therapeutic practice.

I. Through appropriate occupation mainly, (a) simple, supportive psychotherapy for maintenance of healthy mood, and often (b) reversal of the associated state of deconditioning.*

II. Upgrading functional s t r u c t u r e capacity usually involving (a) evaluation of integrated motor acts (ADL); (b) training in integrated movements of limbs, or the whole body to improve or restore purposeful motor activity, or tolerance to activity, respectively; (c) all that is implied in I, particularly I (a), i.e., the psychological concomitants of disability.

III. Frankly psychiatric patients requiring elements of I (a) and (b).

As regards II (c), disturbances of the psyche are usually severe, especially in moderate to severe disability; it will require the added efforts of social service and psychiatry.

In this classification the problems under Step I are the simplest and may serve as a step to training in Step II, which offers more complex situations involving physical, psychological and social disturbances. A medical affiliation for training based upon the first two components in the temporal order presented above, will embody not only principles of progressive teaching, but will afford a comprehensive clinical experience. The only division that need be made in assignment is that between the adult service and pediatrics; but the above classification will fit both services, particularly if brain damaged children (cerebral palsy) are included in the clinical material for pediatrics. Psychiatry has its special problems and will not be considered here. A sample training program for the student in occupational therapy in acute and chronic disease may now be presented referrable to both age groups, each of which in a general hospital setting may be operating simultaneously. The program in all phases combines psychosocial management and disability as a unit:

(A) Adult service.

1. Therapist begins with simple problems of maintaining a healthy mood by supportive techniques; the associated deconditioning state guides the progressive increase of effort.

Case material. Convalescent post-operative and recovering acute infectious and other self-limited

*That state in convalescence, when, after prolonged bed rest, deterioration of cardiovascular, respiratory, neuromuscular and other physiological functions temporarily renders the subject unfit for physical activities ordinarily undertaken without difficulty. It is often associated with exaggerated expression of the patient's dominant personality factor.[1]

conditions; convalescent cardiacs; convalescent tuberculous patients; mild arthritics with no real motor disability; respiratory disabilities such as emphysema (not polio); diabetics achieving metabolic control. (For practical purposes training in therapy for tuberculosis is left to another affiliation unless beds are included in the general hospital).

2. Therapist goes on to all types of disability, starting first with (a) mild to moderate chronic, progressive conditions, with which the patients have lived to some extent and the acute temporary and reversible disabilities; and then proceeds to (b) the progressive and severe, and the permanent but static disabilities.

Case material.

(a) Rheumatoid arthritis with mild or moderate disability; early multiple sclerosis with mild disability; fractures; mild polio; peripheral nerve injuries.

(b) Moderate to severe multiple sclerosis and polio; hemiplegia; paraplegia; severe rheumatoid arthritis; neurosurgical post-operative cases; severe disabling fractures.

(B) Pediatric service

1. Therapist begins with medical problems without motor involvement comparable to the adult service.

Case material. Nephrosis, convalescent acute infectious diseases; then, convalescent rheumatic heart disease, mild disabilities.

2. Goes on to disabilities, mild to severe, as in the adult service.

Case material.

(a) Fractures; early muscular dystrophy.

(b) Still's disease (juvenile rheumatoid arthritis); severer forms of muscular dystrophy; thermal injury in healing stage; cerebral palsy as the most complex, toward a later period in the affiliation. In both A and B, 2, evaluation is emphasized.

The crux of this approach is to take the nondisabled cases first and use them as an introduction to dealing with patients on the psychosocial level. So far this does not seem to differ in content from the G M and S programming. But it does differ in two respects: the terminology and, more important, the fact that it is only an introductory step to the second period of training in a more complex situation. Here the old "orthopedics" will include all disabilities. The student comes to this phase equipped to some extent to understand the psychological consequences of disease. He will be called upon to integrate this with disablement and so gain some insight into rehabilitation. The old "G M and S" and "orthopedics" are thus synthesized into a single, comprehensive, general internship, and the pediatric service is organized along the same lines. By this design we hope that the therapist by practice comes to think of occupational therapy as a single entity, not a loose kind of federation consisting of several mutually exclusive experiences.

We have made the assumption from the beginning that overspecialization is undesirable and have proceeded to discuss measures for its elimination. It may be objected with some conviction that overspecialization is necessary because of the complexity of practice. While this may be true, it is contrary to the spirit, inherent in comprehensive medicine, of regarding the patient as a whole. Occupational therapy will also render greater service if all practictioners are competent to fill the many needs of the average hospital. Thirdly, with the trend toward decrease in morbidity from acute infections and rise in morbidity from age-linked disease and disability, the demands upon the practitioners are more varied. Fourthly, specialization produces a type of learned ignorance which has been described as "knowing a lot about nothing and nothing about a lot." But those reasons are only of minor import.

By far the most cogent reason for avoiding overspecialization is that, if occupational therapy is to thrive and grow in vigor, therapists must be allowed to gain a sense of solidarity in terms of its total mission, and to feel a bond of cohesion springing from the use of common tools, language and processes. If these tools and processes become differentiated into special groups, they may give rise eventually to the impetus of new and formal distinctions and differences; then occupational therapy may ultimately become fragmented into a welter of secessionist and independent specialties striving against each other rather than for the patient. But if a broad outlook is nurtured at the roots of the educational process, the unity of occupational therapy need never be in jeopardy.

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The University of Southern California is offering two graduate courses: Neurophysiology in the Treatment of Neuromuscular Dysfunction, July 11 to 29, instruetor, Miss Margaret S. Rood; Anatomy for Therapists, August 1 to 26, instructor, Mrs. Roxie Morris. Both courses carry three units of graduate credit and tuition for each course is $84. For further information contact:

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EDUCATIONAL TECHNIQUES FOR THE REHABILITATION OF CHRONIC SCHIZOPHRENIC PATIENTS*

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It has been asserted that therapy in contemporary state hospitals involves re-educating the patient to the limits of tolerance which society has for the symptoms of mental illness. Ozarin speaks of social recovery as reflecting the patient's cognizance of this tolerance and his ability to fit into the situation by curtailing behavior which would call attention to him in a negative way. Making this feasible requires that the mental hospital undertake educational activity with the patient through normalizing the hospital environment and training the patient by permitting him, and expecting him, to acquire normal ways of living as a result. In this sense, the hospital becomes a school.[1]

However, the authors feel that the concept of the hospital as a school should be developed further and made more explicit. Education, as generally conceived in state mental hospitals, appears to be of an informal type in which anything that can be taught to the patient through whatever means is considered educational. There should be no quarrel with this, but the educational concept could be usefully broadened and intensified by making clear to the patient that his hospital stay is, in fact, an educational experience, and stressing the educational experience by formal, school-like or "academy" programs. The advantages of such an approach are many. One has already been cited, namely, the accomplishing of social recovery which can and does, of course, proceed through informal educational means as well. Another advantage is that patients respond favorably to the idea of being treated as students. It will be one of the purposes of this paper, at later points, to cite evidence for this contention. Patients are often flattered by being given an opportunity to learn and appreciate and welcome the fact that others have confidence that they are capable of these things. Moreover, in a formalized educational setting, hospitalization itself becomes more meaningful or at least more palatable. It appears to us that patients recognize the social opprobrium attached to the mental hospital. Conversely, they are aware of the high social regard with which the school as an institution is held. It would seem reasonable to assume that the more school-like the hospital can become, the more acceptable the hospital would itself become to patients and staff (faculty) and perhaps to outsiders as well. In this same connection, patients have often told us that they have difficulty understanding why the hospital is called a hospital. They do not suffer from physical illness. They are often well and healthy, spending much of their time working and walking about the grounds. The word "hospital" for many is conceived of in terms of the general hospital where the physically sick are cared for.[2] Again, statements imply, perhaps because of the absence of hospital stereotypy and the presence of total institutionalism, that the situation has more in common with a prison.[3] These allegations are often made by patients without criminal record who resent the presence of criminally insane patients in the hospital. The prison, of course, has lower social status than the mental hospital. The similarity of hospital and prison could be obviated by stressing education within the hospital. As stated earlier, such could also make the hospital experience more meaningful and in closer accord with an acceptable social institution. Also the presentation of ideas and the world of material things have especial value to that class of patient, generally schizophrenic, which has trouble orienting in these areas.

Other values of education in the state hospital include the opportunity to expand the group therapy process by developing positive interpersonal relations between patient and instructor and constructive use of time, a commodity with which the mental patient is overburdened.

DEFINITION OF FORMAL EDUCATION

The type of formal educational program envisioned by the writers is of such a nature that all patients regardless of formal schooling and intellectual ability can participate. We are not primarily discussing adult education courses leading to a high school diploma or extension of schooling for those patients of school age. We

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feel that such programs should be present, but we are more concerned with techniques of organization and pedagogy which are utilized by educational institutions and less concerned with the content of educational material or the measurement of its inculcation in patients or by periods of time.

By defining an educational project in these terms, we place it at the disposal of all patients and overcome the limitations of low intelligence and psychotic disturbance as bars to participation. The individual patient may acquire what he can or wishes to acquire from the experience.

BACKGROUND TO OUR EXPERIENCE

Our first motivation leading to consideration of an educational approach at the Vermont State Hospital was occasioned by our observation that patients referred to group therapy as "classes." We do not know, since this terminology exists with attendants as well, whether it originated with patients. The fact remains, however, that the concept of group therapy sessions as classes is congenial to patients. This suggests implicitly a desire for school-like activity. One could argue that the term "class" might be used for a disliked activity. There is no evidence, however, that the group therapy sessions are disliked.

One of the writers also observed that members of his therapy group responded very positively to intellectual or cultural information in group therapy sessions.

Some of the cultural and intellectual material especially well received included a patient's presentation of two lectures on the Soviet Union; reading and discussion of an essay by Dostoievsky; a reading of a Kaffka short story followed by an attempted analysis; the writing and presentation, with the help of the leader, of a play depicting the rehabilitation process; discussion of current events, and listening to classical music followed by appraisal. Classical music in particular became very popular with the group. Members requested such music on several occasions and urged the re-playing of certain works.

At the same time as the above observations were being made, the occupational therapy department within the hospital came to consider the need of an "elective course" approach in its work because scheduled activities in the department were all chosen by staff members with patients assigned to specific activities. The result was a series of complaints from patients concerning the limits of choice and range of activities offered. Morever the vocational counselors assigned to the project felt that the occupational therapy department was not too useful in the area of evaluating patient skills. The counselors urged that courses be set up in homemaking and shopwork in particular which could serve as apprenticeships for those patients wishing future employment in these areas.

In addition to all of the above, occasionally a patient would remark on the need for more educational direction in the hospital program. As a result of these motivations, several educational practices were developed within the rehabilitation project. One set of activities centered about the occupational therapy department, while the other was not specifically connected with any hospital department. We will next describe and evaluate this activities in detail.

OCCUPATIONAL THERAPY ACTIVITIES AS FORMAL CLASSES

In January, 1959, the occupational therapy department re-organized with the selected group of open ward rehabilitation patients along "academy" lines. A series of proposed courses were drawn up by the OT department members and all rehabilitation patients were requested to indicate on a special sheet their first, second and third choices from the list. The courses to be offered were homemaking activities, carpentry, printing, weaving, dressmaking, reading and learning techniques, shopwork, cooking, arts and crafts—oil painting, leather carving and tooling, ceramics, music and drama, typing, bookbinding and group dancing.

After all the patients had made choices, classes were organized. In some cases, if a given class was too large, some patients were asked to accept the class of their second or third choice. Classes ranged in size from six to fifteen students with one worker assigned to each class. In most cases, patients were able to enroll in the class of first choice, and in all cases patients were able to enroll in a class they had expressed some desire to take. All but the homemaking class were co-educational.

Classes were organized for a six-week period. This was explained to the patients with the further reminder that at the end of this time, new selections of courses would be made. It was explained further that, in most cases, a change in course would be necessary. In a few instances, such as typing, which probably would not be mastered sufficiently in six weeks, a course could be repeated.

Each class was scheduled for two meetings per week. Each meeting was of two-hours duration. The classes were more tightly organized than had been true of earlier occupational therapy activities. Specific goals to be accomplished were set up. On the other hand, patients were permitted a wide range of choice within this framework. Thus, for example, in the cooking

class, the objective was instruction in techniques of food ordering and preparation. However, the matter of menus and the type of preparation were left to the patients. In carpentry, the goal was instruction in the care and creative handling of small tools. Each patient was free to make a choice of project within the objective. Some of the classes involved considerable group planning and also offered opportunity for smaller group interaction. Certain of the classes, such as typing and weaving, allowed less individual choice and required uniform attempts toward mastery of a skill.

After twelve weeks, or two "semesters," the occupational therapy department evaluated the results of its new program. It was felt, first of all, that the program had great value to the *staff*. Since the course offerings had been mapped out according to the abilities of the staff, each teacher felt a reasonable competence and liking for the subject taught. The more formal class approach allowed for easier appraisal of patients' work. In the past, staff members might have several patients working at different tasks over longer periods of time, which presented problems in evaluating the accomplishments of both teacher and student.

Most important of all, however, was the reduction of staff anxiety. Not only was each member performing in areas of competence and choice, but there was assurance that the needs and wishes of the patient were being met through the activity. It was comforting to know that patients had "signed up" for the course.

Attendants became more favorably impressed with the occupational therapy program because of their gain in understanding through the co-educational nature of the classes. Male attendants brought patients to the female shops, for instance.

From the patients' point of view, complaints concerning occupational therapy were minimized. There was satisfaction with the program. Former complaints concerning lack of choice and range of activity were no longer valid. One of the writers noted in his group therapy section that the members commented frequently and favorably concerning the activities. Occupational therapy was never discussed by them in group therapy before the re-organization took place.

Moreover, as the program unfolded, a wholesome sharing took place among the various classes. For example, if the cooking class had extra food, it invited other classes meeting close by to share it. If the music and drama class obtained an interesting film, it invited other classes to share the viewing. In addition, the interaction among members in a given class was increased as cooperation and sub-group activities increased.

It was also the feeling of the authors that the patients were coming to think in terms of education and "classes" rather than of the occupational therapy department. The classes were in format similar to the group therapy "classes." Other courses yet to be described were going on in the evening in the occupational therapy rooms. It appeared, therefore, that a new and unifying concept of education was beginning to permeate the patients' thinking and helped to give a central meaning to more of their hospital experience.

SOCIOLOGY CLASSES

On January 7, 1959, one of the writers organized an informal class entitled "Social Problems in America" for patients of both sexes of the rehabilitation project. The class was intended as an elective activity for the one hundred and ten patients with whom the project was concerned. No prerequisites of education or previous acquaintanceship in the field of social problems were required. The course was organized to continue on a one meeting a week basis for six weeks. Each class was to last for one and one-half hours with a coffee break of about fifteen minutes at the half-way point. Naturally no assignments were to be given in the course or grades awarded. Participants were free to come or stay away as they were inclined.

The response to the class was so enthusiastic that it was decided by the members at the last meeting to continue with another subject. The leader presented the group with a choice of five possible subjects. These were sociology, anthropology, archeology, ethics and philosophy. These courses were suggested because various patients had expressed an interest in them. At the time of the selection of the new course, sheets explaining the content of each subject were distributed. It was decided that the course receiving the highest number of votes would be offered. Sociology was chosen, defeating ethics by a margin of one ballot.

ANALYSIS OF PATIENT REACTION

Attendance at the two classes varied from a low of twenty-two to a high of thirty-five. High and low points in attendance did not follow any chronological pattern. The attendance was considered good since the meeting night conflicted with the showing of movies for female patients. It was not possible to find an evening without conflict with another activity. There was no significant difference in sex distribution at the meetings. On one or two nights, men outnumbered women because of the attraction of the film offered, but, by and large, sex distribution was approximately equal.

The majority of the patients had less than a high school education. A very few had attended college, and some had no formal schooling of any kind. Lack of education did not discourage some patients from attending or from participating. A minority of patients were mentally deficient, but some of these were active participants in the discussions.

PROCEDURE

At all sessions, the leader prepared informal lectures. These were designed to stimulate discussion and seldom failed to do so. Although the purpose of the lectures was not didactic, their material was a faithful presentation of facts available on the topic under discussion. Technical vocabulary was avoided, but, apart from this, the leader tried not to "talk down" to the students. Unquestionably, the material may have been too complicated for some in the group to handle but, by and large, the impression was that the basic content was getting across.

Discussion was encouraged and any topic or question, no matter how much of a digression it represented, was considered. The leader tried at all times to answer any question with full candor and further attempted to thoroughly consider all sides of controversial questions. At one meeting, there was a lengthy and frank discussion about homosexuality and sexual perversions. One patient said, "You never could have an honest discussion like this on the outside."

In some respects, procedures differed between the two courses. The students chose the topics of discussion in the social problems course. A list of possible topics was drawn up on the blackboard and a vote was taken to decide which of these would be discussed in class. Topics chosen were mental illness, crime, narcotics addition, divorce, and the crisis in education.

The leader suggested that some of the students might like to present reports to the class on some of these topics. Four of the members volunteered to do this and brief papers were presented. For purposes of these reports, the leader made standard textbooks available. All reporters used these, but some supplemented their source material from volumes and magazines available in the hospital library.

During the social problems class, the leader prepared brief summaries of each session, plus an overall review of the class. Copies were circulated among the students.

During the sociology class, the leader made his own selection of topics and no reports were presented. He felt that the material was more complex and required greater direction on his part. Topics discussed were the importance of the group, man as an animal, culture, social processes, and rural-urban differences. On the other hand, a volunteer secretary served at each meeting and recorded the discussion in outline form. Copies of these records were circulated among the students.

As stated above, discussion was encouraged and wide deviations from the subject permitted. However, in two realms, the leader attempted to control the activity of the group. One of these areas involved discipline. On occasion, some patients whispered and talked while the leader or some class member was trying to make a point. The leader made it clear that rudeness of this type would not be permitted. One or two reminders were sufficient to restore order. By and large, attention was good and instances of rudeness were few in number. Secondly, the leader considered it his duty to correct erroneous ideas and to attempt to formulate opinion in a constructive way. An example, taken from the leader's tape-recording of his impressions of a meeting done after its conclusion, illustrates this attempt.

Subject: *Mental Illness.*

The role of the attendants came up for discussion. There were several points of view here. One group seemed to feel that attendants should be better trained and have college degrees. This point was discussed at some length. Finally, I suggested that a college education would not help an attendant do his job. His is a problem in interpersonal relationships and that is not an educational matter. Too much education might raise the danger of intellectualizing the human relationship and might overprofessionalize the attendant role. After more discussion, my point appeared accepted. We then went on to agree that attendants do help patients in many ways and that they certainly need to be given more status and more money.

By and large, however, the instances of the leaders' attempt to mold opinion in the group were relatively few. The major reason for doing so in the above instance stemmed from his fear that the positive role of the attendant in our hospital might be lost sight of due to the fact that none of the rehabilitation ward attendants have college degrees.

VALUE OF THE COURSES

The leader's retrospective analysis of the courses lead him to conclude that they had value in the following areas:

1. *As focal points of intellectual discussion.* Although ideas were often presented clumsily and in discursive fashion, the leader was convinced that mental patients, given a chance, enjoy intellectual discussion and that in spite of limits in formal schooling are often able to think incisively. The following quotation illustrates this point.

Subject: *Deciding on Topics for Discussion in Social Problems.*

After we had placed on the blackboard a lengthy list of topics to choose from, one patient said, "What

is a social problem?" As a result, we tried to differentiate a social problem from a personal problem. One man stated that a problem is anything that is represented by a painful, frustrating situation which requires an adjustment. Two individuals disagreed with this, suggesting that some problems are intriguing and are not characterized by pain. This led us to consider the difference between a painful problem and solving a cross word puzzle. We concluded that we were concerned with the former kind of problem. However, the question of the difference between a personal problem and a social problem still remained. The leader suggested that the difference might be in terms of the numbers of people involved. One man's death might affect only his family, but the death of the President of the United States might affect all Americans. One patient objected to this on the grounds that "no man's problem is unique to himself. Everybody in some way affects everybody else." We thus agreed that all problems affecting people are social. Finally, we decided that social problems, for our purposes, were those which obviously affected a good many people, directly or indirectly.

Often, textbooks in social problems begin with just this type of discussion.

2. *As satisfaction of the need for cultural fulfillment.* At some points, the leader was dubious as to whether or not a topic chosen by him would hold much interest for the group. One such topic was urban influence in the United States. The group was largely rural in background; however, stimulating questions about cities and their growth followed this presentation. As the result of a number of similar experiences, the leader was forced to conclude that mental patients feel a need to broaden cultural horizons and are flattened at being given an opportunity to come to grips with the world's knowledge. We may have made the mistake of thinking that simply because mental patients are barred from extensive participation in society, they are thereby less interested in it. It seems to this writer that mental patients with whom he has worked have revealed a hunger to learn. They feel a satisfaction in learning about almost any topic.[4] This learning experience is especially valuable for those patients who have difficulty in relating to the world of ideas and things.

3. *As media for group therapy.* One patient remarked to the leader during a coffee break, "We seem to move from discussion of the topic to a discussion of personal problems and then back again. Sometimes this seems as much like a large therapy session as it does a class." This appraisal was correct. The frankness of the discussion and the breadth of deviations represented points at which the classes moved into the area of group therapy. Morever, the coffee break time was often used by individual patients to single out the leader and discuss with him personal problems or further ramifications of the classes. As time went on, it seemed to the leader that many patients "saved up" problems affecting them through the week for discussion at the class.

4. *As variety within hospital routine.* For many, the chief value of the classes may have been in the opportunity to get off the ward for a part of the evening, have a "bonus" cup of coffee, or have the opportunity to spend time with members of the opposite sex. The introduction of variety into the rather rigid schedule of hospital routine was unquesionably very important. As one patient said, when the question arose as to whether or not to continue with another course, "Let's go on because it gives us something to do." Several others chorused assent to this.

THE LECTURE SERIES

With the conclusion of the sociology course, the leader proposed that the group consider a series of lectures by guest speakers instead of another course. His reasons for doing this were fourfold. (1) A too-long continuation of the course idea might eventually rob it of its novelty. It has been our experience in rehabilitation work that changes in programming are necessary in order to keep the hopes and interests of the patients alive. (2) A too-long subjection to the leader's fund of knowledge, pedagogical techniques, and personality might result in loss of ultimate value. One person has only so much to say. Beyond that point, someone else can say it better. (3) It seemed important to give the group a larger share in planning the meetings. The format for the classes had become rather routinue. The bringing in of guest speakers necessitated patient committees to plan schedules and issue invitations, plan and serve refreshments, and the like. (4) The use of guest speakers would involve members of the community in a wholesome activity with patients as well as providing an educational experience for both patient and guest.

The idea of a series of guest lecturers speaking on topics of their choosing was enthusiastically received. A committee was chosen to work with the leader in selecting speakers and arranging dates for a series of four lectures. The prospective speakers were contacted by the leader and gladly agreed to attend. A letter of appreciation of acceptance was drafted by the committee and sent to each. Three of the four speakers were in no way connected with the hospital, while the fourth does hold a hospital position. The selected speakers represent the following areas: radio communication, anthropology, public relations in the insurance field, and psychiatric nursing.

At this writing, the patients and the leader expectantly await the beginning of the lecture series. If the first speakers are well received, it

is hoped that the series may be extended. The experience of others working in this area leads us to expect good results.[5]

CONCLUSION

The use of formalized educational techniques in mental hospitals, although not perhaps used extensively[6,7] seems to offer beneficial therapeutic results. In a sense, the introduction of lectures and classes does not represent a new and experimental approach, but rather represents a return to therapeutic techniques deemed useful during the latter part of the nineteenth century.[8]

We would emphasize that education within the state hospital should have two purposes. The first, ordinarily encompassed within the occupational therapy department, should stress vocational training and the development of skills primarily. This may be thought of as practical preparation for functional return to the community. The second purpose should be instruction in intellectual and cultivated areas in order to make the hospital experience more meaningful and give the patient a feeling of accomplishment that he can participate in a larger share of the culture's learning. As suggested earlier, other benefits should accrue to both patients and staff as both purposes are fulfilled. We might add here that as industrial therapy in Vermont State Hospital has come more and more to be viewed as a training experience for the patient rather than as a work function benefiting the operation of the hospital, both patient and staff have benefited. The patient views his job as a learning experience and supervisors see themselves as responsible for a teaching role.

In conclusion, there is every reason to continue the informal educational approach. Formalized classes are not substitutes for the everyday learning experience, but rather a more concrete expression of the educational goal within the hospital setting.

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The OT as a Therapist . . .

(*Continued from page* 3)

given the basic desire to work with people, the anxieties, depressions, and the needs for prestige or fears of defeat can find some solutions. Close supervision, and the working through of individual problems in the therapists, is the hope for effective therapeutic effort in occupational therapy.

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PSYCHIATRIC OCCUPATIONAL THERAPY IN A MILIEU SETTING*

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Occupational therapy at the Ann Arbor Veterans Administration Hospital on the psychiatric service is an integral part of the overall milieu therapy. The milieu program at this hospital is unusual in the opportunity it allows for a more intense staff participation in "patterning" the patient and helping him to realize and work on his problems. This treatment is based on group-oriented activity and on frequent and diffuse contact between patients and staff. The psychiatrist encourages all staff members to develop meaningful relationships with each patient as they participate in the activities. Also, the group interaction is important in reality-testing situations and in developing socialization skills.

There are two 40 bed psychiatric wards, one locked and one open, which are similar in aims and techniques. The patients are all male veterans, voluntarily admitted. The diagnoses treated are schizophrenia, depressive and anxiety reactions, character disorders, and psychosomatic disturbances. Each ward is divided into three workable groups of patients for treatment purposes.

The activity day includes occupational therapy, group therapy, and adapted sports, as well as music therapy, library visits, art therapy, and dances. Each patient is expected and encouraged to take full part in all activities.

In occupational therapy, craft activities are our media. In this we make a unique contribution in having visible evidence of the patient's performance and, as well, the patient relaxes barriers when he feels his work, rather than himself, is being observed. We have direct contact with each patient in the three groups every day, while most staff members work with only a portion of the total patient population. In most other ways the treatment of the patients very closely parallels that of allied services and it is difficult to draw distinguishing lines.

The occupational therapy treatment of the open and closed ward patients is separate, taking place in two different clinics. The closed ward groups are escorted to the clinic by an aide who remains with them throughout the period. The open ward patients are free to come and go by themselves as scheduled.

Milieu therapy is attitude-oriented with a specific individual attitude prescribed by the psychiatrist for each patient. The attitudes are consistently applied by staff members in all therapies, and fall into several main categories. The most frequently indicated are warm acceptance, firmness and anti-depressive. These basic attitudes may also be combined.

In the occupational therapy clinics, they are carried through in the following ways:

Warm acceptance. This prescription indicates that the patient is to be supported in a very giving, positive relationship. In most cases, he is to be allowed some freedom in choosing his work, or helped to make a choice if he is unable to make decisions. Effort is made to foster as much independence as possible but the therapist is available when help is needed. The patient is praised for his effort even though he may be too ill to work efficiently. To help the patient recognize and work with his problems, it is sometimes necessary to focus on obvious manifestations of them, turning his attention to what is happening "right now" and asking him to look at what he is doing. The therapist recognizes with the patient what gains he has made and where he continues to have difficulty.

Warmth with firmness. This prescription implies a setting of limits for the patient in a firm but accepting way. This applies when the patient is unable to set his own goals or follow his daily routine. Instructions for projects are given in small units and the patient is expected to complete each step before proceeding to the next. This requires that the therapist check frequently with the patient when he is testing boundaries, quietly pointing out his work and the pattern to be followed. The patient knows that he is expected to perform in a certain way, and he is warmly reminded of these expectations. Every effort is made to keep the relationship on a positive basis, even though the patient may resist the firmness of the therapist.

Anti-depressive.[1] This attitude is the subject of a research study at this hospital. It is so named because it is felt that in selected cases it

*The views expressed are those of the authors and do not necessarily represent the opinions or policy of the Veterans Administration.

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helps to alleviate depression without the use of EST or other similar treatment methods. A task routine is used to satisfy the patient's need for punishment resulting from internalized anger and consequently helps to relieve depression. He is assigned unrewarding tasks such as smoothing rough boards or cleaning various areas of the clinic. Patients on this prescription are given no gratification or support. Firmness with no warmth is shown. Their work is frequently examined and, if any comment is made, it is constructive criticism of the job being done. Most frequently, patient resentment of the work is first evidenced in the form of requests for a change to some other work; then complaints, leading to a refusal of the task or other outward expression of anger. If a patient on the anti-depressive regime verbalizes, the therapist allows him to ventilate but gives no sympathy. He is encouraged to bring up his feelings for discussion with his psychiatrist and in group therapy meetings. It takes longer for some patients to refuse, and some are never able to verbalize their feelings or to be really firm. Sometimes a patient may approach this point, but becomes too frightened to refuse the work. It is not necessary that each patient reach the same peak of assertiveness before his prescription is altered. Depending on the individual, the prescription is changed by the psychiatrist at the optimum time for his treatment. This anti-depressive attitude is found to be very effective in many cases. Contraindications are an extreme lack of ego strength, a strong element of masochism, or intense fear of the consequence of expressing anger.

Half and half anti-depressive. A patient with this prescription is involved in a modified anti-depressive routine which is calculated to help relieve depression and improve motivation when combined with work of the patient's own choice for half of the period. In contrast to the full anti-depressive program, the attitude is more matter-of-fact. The patient spends the first half of the period doing assigned cleaning, construction, or refinishing tasks. He is working off suppressed feelings through his assignment. During the latter part of the period he is receiving some gratification through his own projects. One patient will keep at a task until reminded to stop, while another will try to avoid the assignment entirely.

The full anti-depressive program is utilized more frequently on the closed ward, while the half-and-half attitude is more common on the open ward. Where the patients have the freedom of the unlocked doors to the occupational therapy clinic, the complete anti-depressive program is not always practical. If a patient is angered or frustrated to the point of leaving the clinic and refusing to return, the effectiveness of the treatment may be lost.

Whatever attitude is prescribed, individual treatment objectives are also set. These may be altered to fit the patient's needs as he progresses.

Within the milieu framework, treatment is calculated to help the patients learn or relearn more acceptable reactions to life situations. In general, they learn what acceptable behavior is in a group setting. In the occupational therapy clinic and other hospital situations, they are encouraged to express themselves more freely in a verbal way. They begin to be aware of their own limitations and live more comfortably within them. They are constantly encouraged to deal with the present reality situation.

During the more acute phase of illness, the emphasis is placed on support. As a patient's personality becomes more intact, patterning is begun. For instance, a patient who is impulsive in his actions or autistic (preoccupied) will need to establish regular thinking patterns or routines. This is done by encouraging the patient to plan well, rather than performing impulsively. Awareness of personality problems and areas where work is needed can be emphasized by pointing out deviant patterns in the patient's work habits and keeping him aware that he is in treatment and must continue to work. He is first helped to look at his behavior and helped to recognize where his problems are. Often the patient is more able to see a difficulty when it is pointed out to him at the moment it occurs, before he has forgotten the incident. The realistic situations which occur while a patient is engaged in activity are ideal for this type of confrontation. He is encouraged to think before acting, to plan and get steps in mind, and then perform them in their proper sequence. After the pattern is established, the therapist continues to work with him, praising him where he has done well and calling his deviations to his attention in an accepting, helpful manner.

Often the patient focuses on a constructive comment, construing it as a criticism. When this happens, the therapist must be alert to his attitude and reassure him strongly that this is constructive suggestion, and that if he chooses, he may take advantage of having these things pointed out, and change his pattern. A very negative reaction can be circumvented in this way. It is constantly stressed that verbal expression of feelings is acceptable rather than acting-out behavior. As these feelings are verbalized, the patient is encouraged to discuss them more fully

with other staff members and in group therapy. When the patient begins to produce new material with the therapist, he is allowed some ventilation, but is then encouraged to take this to the group therapy setting. Often he is shy about bringing these things to his group until he has tested some staff member's reaction to his recount of "bad behavior." When he understands that he is not being judged or condemned, he is then likely to feel more secure about confiding in others and working it out.

A frequent point of conflict is in the area of sexual identification. As the patient group is composed of male veterans, emphasis is placed on the more masculine activities. Situations are devised where the patient has opportunity to play a dominant role: sharing his knowledge of tools; learning a new technique with the therapist. Also he is encouraged to develop attributes considered to be more masculine. (In a recent study, at this hospital, it was found that metal hammering and woodworking were considered by a majority of the patients to be more masculine activities.[2])

Many patients find it extremely difficult to relate in a group. As consistently as possible, occasions are created for patients isolating themselves to help them become more a part of the group. A patient may be given a small responsibility to aid in his socialization. For example, he may be responsible for making the coffee for the coffee hour held each morning in the open ward clinic. In this way, the other patients depend on him and he is recognized as a group member although he may not actively socialize with them. Projects for the ward are planned to further group unity. These are planned by the patients, with staff approval, and carried out by the patients themselves, working in small groups of two or more. When a patient has shown his ability to relate with group members, but still tends to isolate, he must be firmly urged to stay with the group and make some effort to be a part of it.

Except in the anti-depressive routine, a warm support is our most important tool. Psychiatric patients show effects of much disapproval and rejection. Sometimes no progress can be made until great amounts of warmth, by all staff members, have been consistently shown for a period of time, and only then is the patient ready or secure enough to reach out for the next step. This warmth is shown in many ways. Non-verbal reassurances are the most basic. A mute patient, who cannot speak or tolerate conversation from others, can derive great benefit from a staff member just sitting with him in a one-to-one situation, making little or no comment. Evidence is not observable of any response to this except for an occasional faint smile from the patient or more alertness. Another way in which the non-verbal approach is used is in the offering of coffee, candy or gum. Many times the patient will show much ambivalence about accepting these, but with few exceptions, will take them if the offer is made again in a few minutes, or the candy left near him.

Next are spoken reassurances of understanding and wanting to help. Conversation at this time, even though strictly from the therapist, is limited to very simple observations, references to the patient's interests, and so on. Also he is praised for any slight movement toward participation.

Finally, as he bcomes more outgoing, the patient is encouraged to talk about his difficulties and take them into the group. There, the group leaders and members can help him deal with the problem in the group setting.

Emphasis is not on individual sessions with a psychiatrist, but rather on treatment of individuals within the group setting. Usually one or or two of the staff will relate particularly well with any one patient, as is encouraged in our milieu program. With the limited staff, it is essential that we each make the most meaningful possible relationship with each patient. It is felt that numerous relationships will help carry the patient through both positive and negative phases of treatment.

We work directly with the patients' outward verbal expression of strong positive and negative feelings. Because of the directness with which we point out difficulties, the patient may feel free to express unusually strong hostile or warm feelings toward the staff member. We have had to learn how to deal with and understand this direct expression in order to eliminate unfavorable responses in ourselves. With the psychiatrist and staff, we have set up specific ways of dealing with these emotional outbursts. If a patient threatens or gestures towards acting out in a hostile fashion, he is assured that acting out will not be allowed, though he is encouraged to verbalize his feelings. Similarly, in positive expression, limits are also set and almost invariably the patient is more comfortable when this is done. We have learned to recognize that emotional outbursts are usually related to the patient's long-term difficulty in dealing with certain types of personalities, or to a current stress situation, rather than personal dislike of the therapist. When the therapist senses that the patient is angry, but not expressing it, she may say directly, "does this irritate you?" or "you seem to be angry." The use of this technique depends

upon the patient's acceptance of hostility. When the patient does ventilate his angry feelings, a positive situation is made of this by reassuring him that "it is good that you can let us know how you are feeling about this." We have found that expression of extremely positive feelings also can leave the staff uneasy. If the patient calls the therapist by a familiar name or makes attempts to touch her, he is told directly, but warmly, that "when you are feeling positively toward a staff member, you can express it in a verbal way."

The patients are individually referred to occupational therapy by the psychiatrist. The prescription is received by the therapist prior to the patient's initial treatment. Also, the patient has usually been thoroughly discussed in staff meeting before he comes to the clinic. This familiarizes the therapist with a brief patient history, outstanding dynamics, aims, and the specific attitude which is to be assumed toward the patient. With this information available, the therapist is confidently able to plan for the patient's treatment program, knowing that she is consistent with other disciplines.

Each of the two occupational therapists working with psychiatric patients has a weekly meeting with each psychiatrist on her service. At this time, specific treatment problems are discussed and dynamics further explained. In case of an unusual situation, the psychiatrist can be immediately contacted for advice and help on a specific problem. This immediate action can mean the difference between a successful resolution of the current problem or a possible setback in the patient's progress. This is, of course, necessary only in an emergency.

The staff is a closely integrated unit which meets regularly, twice a week. At the meetings, all members contribute observations of the patient and assist in decision-making. Time is allowed for each person to comment, as completely but briefly as possible, presenting new and pertinent material. Significant changes are promptly related by way of these meetings so that everyone is aware of current problems. We respect each other as equals with professional skills in our own specialties. Our contributions are often similar, but vary according to our medium of treatment.

There is a "family staff" feeling. Members of the staff feel free to express their opinions because value is attributed to everyone's ideas. The psychiatrist utilizes the observations of the staff in final decisions. The contributions of staff members give a complete picture of the patient's performance in all parts of the program. As a result of this, there is more vital interest in the patient as a total person, with problems we can all help solve in inter-related ways. The patient group is aware of the closeness of staff communication, and is also aware that sharing of staff knowledge about the patient is essential for optimum treatment benefits.

Important to our program is ongoing instruction. There are scheduled evening seminars dealing with specific aspects of the program. These may deal with problems of the whole staff or of a particular service, proposals for changes in the program or with research and papers for publication. These seminars are well attended by all services.

SUMMARY

The starting point for the milieu therapy program is the attitude prescription applied as uniformly as possible within the limit of staff personalities. This concentration of attitude provides stability for the patient. We also feel it provides him with a more uniform basis for testing his reactions. The good communication of the staff plays a large part and is essential in setting limits for these patients.

We feel that our occupational therapy program in the milieu provides a more complete use of staff-patient and patient-patient relationships, in an active workshop situation. The patient gains a better understanding of his ways of reacting through his own and other patients' interaction in the clinic. He is helped to recognize his problems and to handle frustrations and anxieties. We have found that in occupational therapy it is possible to pattern the patients in their work in such a way that they can begin to face everyday situations in a more logical, better-planned way.

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ORIENTATION TO PROSTHESIS USE FOR THE CHILD AMPUTEE*

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At the UCLA Child Amputee Prosthetics Project (CAPP), prosthesis training for upper-extremity child amputees is generally considered to have four phases—orientation, controls training, activity training and follow-up. This paper deals with the first of these.

When an upper-extremity child amputee gets his first prosthesis a whole world of questions opens before him and his family. Before the fitting is done they will have received some preparation from the staff of the prosthetics team. Usually a physician, psychologist or social worker will have helped the family to understand and accept the reasons for their child's having a prosthesis. The prosthetist will have shown the family the new arm in the fitting stages, and will have explained to the amputee some of the operation of the control system in the harnessing. But the therapist who will work with the child and his family in the day-to-day process of learning to use the arm still has much to offer in the way of orientation.

The care and function of the new prosthesis should be fully explained and demonstrated to the child and his parents by the therapist. It is essential that they learn what to expect from the new arm; how to take care of it as well as how to use it. The child must be helped to feel comfortable about handling and wearing the prosthesis before he can accept it. Careful handling and respect shown for the prosthesis by the therapist will help to emphasize its importance. The child will also be more comfortable with the new arm when he learns some of the things he can and cannot do with it.

Ideally, the unilateral child amputee comes to think of the arm as his "helper" and often refers to it this way at home, at school and in the training room. This term has been generally adopted by many amputee children. The word "helper" tells not only what the prosthesis is but what it does. It is the *assisting* hand and should not be expected to be used as a lead extremity. Parents, too, should see the prosthesis as the assisting arm so that they will not "push" the child to use the arm for such activities as eating or writing.

The parents are often apprehensive at first about how to introduce the prosthesis to the children in the neighborhood and to the school. This uncertainty may stem from deeper feelings of apprehension about their own acceptance of the prosthesis and a psychologist or social worker may be needed to assist them in understanding their feelings about the prosthesis.[1] Usually it is a great help if a parent or the therapist contacts the teacher before the child's first day and introduces the child with the prosthesis to the teacher who in turn will prepare the class for the child's entry. The teacher can support and encourage the child to show his prosthesis to others in the class. Generally the child will demonstrate to his schoolmates and others who are interested just how the prosthesis works. He will show them what it looks like and offer to let them inspect it if they wish. With effective handling he will find the prosthesis a source of prestige rather than a symbol of inferiority.[2] Early school contact by the therapist provides the teacher with an added source of information should any questions or problems arise about the wearing or use of the prosthesis in school.

Children wearing prostheses have been observed to have a great deal of respect for the safety of others around them. At CAPP we have seen no incidents of injury willfully inflicted with a prosthesis to date. Even the youngest children seem to have an unspoken awareness in this area.

WEARING THE PROSTHESIS

For development of wearing tolerance and a wearing habit, good fit and function of the arm and an understanding of the child's individual activity pattern are necessary. The child must be assured, for instance, that he is not going to be expected to put the arm on and never take it off. There are some things which can be done better without a prosthesis, i.e., sleeping and bathing. Some children can begin full-time wearing immediately, while others need to build wearing tolerance gradually. Often the therapist can help the child to incorporate prosthetic wearing habits into his other daily habits by thinking through the child's day with the parent. For example, the child may plan to put the prosthesis on with his clothes in the morning, wear it to school, take if off for rough outdoor play, and put it on again for dinner and indoor play until bedtime. The therapist should help the family chose a plan that is realistically attainable in terms of their child's level of acceptance and

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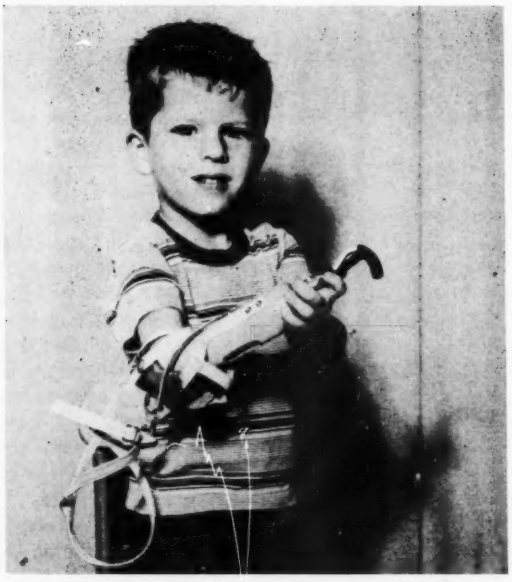

Figure 1

then build gradually to the goal of full-day wearing. For example, some children prefer to wear their prosthesis for outdoor sports. Swinging, sandbox play, and even baseball may or may not be activities for which the child finds a prosthesis helpful. Most important, for each child a definite but realistic individual wearing pattern needs to be established. Without this, the child will be constantly testing the parent to see how much he is really expected to wear the new arm. If punishment accompanies this testing, the whole prosthetic experience may become very negative. Prosthesis wearing should be a positive experience.

Early in the training program the child learns how to put on and remove the prosthesis. For the below-elbow amputee this is done in the same manner as putting on a coat. The socket is grasped with the sound arm and the stump is slipped in under the inverted Y-strap (Figure 1). The prosthesis is then raised above the head, allowing the harness to hang down. The sound arm reaches back and through the axilla loop as it would through a coat sleeve (Figure 2). The harness can then be settled into place with a shrug of the shoulders.

The short above-elbow amputee with a figure-of-eight harness puts on the prosthesis by placing the sound arm through the axilla loop, raising the arm and sliding the loop into position, allowing the prosthesis to hang down in the back with the harness straight. By leaning to the amputation side the prosthesis can then be moved into position so that the sound hand can reach across the front of the body, grasp the socket, and hold it so the stump can be inserted. The child then shrugs his shoulders to settle the harness into place. As an alternate method, the standard above elbow amputee may put on the prosthesis by first inserting the stump into the socket and then placing the sound arm through the axilla loop as does the below elbow amputee.[3] The unilateral above-elbow amputee with a chest strap or the amputee with a shoulder disarticulation, after putting his prosthesis in place on the stump stabilizes it against a wall or by leaning the extended forearm on a table surface and then pulls the chest strap of the harness around to fasten it (Figure 3.)

Figure 2

To remove the below-elbow (BE) prosthesis have the child raise both arms above the head, grasp the socket with his sound arm, withdraw the stump while pulling up on the socket, and then remove the axilla loop. If the harness is kept from tangling it will be easier to put on next time.[3] Above-elbow (AE) and shoulder-disarticulation amputees remove prostheses by reversing the application process. Buckle and snap adjustments should remain in place while the prosthesis is applied and removed.[3]

The bilateral amputees (BE and/or AE) may first pre-position the prostheses on a table, front side up, with the harness straight. With the bilateral below elbow, the shorter stump is inserted under the harness and into its prosthesis first, while the longer stump stabilizes the prosthesis. After the longer stump has been inserted, the arms are raised so that the harness may be flipped over the head and shrugged into place (Figures 4 and 5). As an alternate method for the BE or AE the prostheses may be put on like a coat. In this method the longest stump goes into its prosthesis first. This stump and socket is then elevated allowing the other prosthesis to hang diagonally across the back. By leaning

Figure 3

to one side, the short stump can be inserted into the prosthesis and the harness shrugged into place.[3] For the bilateral shoulder disarticulation amputee one possible method is to lean back on a table into the pre-positioned sockets, hold the sockets on by setting his muscles and abduct his scapulae to hook the chest strap (Figure 6). All of the above processes are reversed to remove the prostheses. There are so many variations of these procedures that only those commonly used are mentioned here. Any individual child may find another way which is better for him.

A stump sock is usually worn to absorb perspiration, prevent suction, and allow greater comfort in the socket. Tubular stockinette stitched together at one end is usually used but an ordinary bobby sock will do. (These are usually cotton. However, a study of the best type and material for these socks would be helpful.) Some children with the below-elbow type of amputation prefer not to wear a stump sock. For them it is a matter of individual choice. Socks should be washed in soap rather than detergent to avoid skin problems. They should be changed frequently. It is also important to wash the stump often. The perspiration which gathers there may cause skin problems. Prolonged stump irritation may necessitate a period of non-wearing of prosthesis which can further hinder development of a wearing pattern.

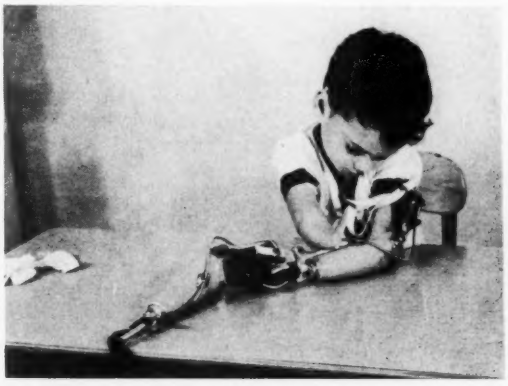

Figure 4

It is recommended that the amputee wear a T-shirt under his harness for several reasons. The T-shirt tends to keep the harness cleaner by absorbing perspiration, and serves as a padding under the harness, decreasing local irritation and pressure, especially in the axilla area. On first wearing the prosthesis the child may experience some soreness in the axilla, but with continued wearing it becomes toughened and if there is smooth operation of controls this reaction point will "set" without discomfort. Children generally get to the point of wearing the prosthesis comfortably over a T-shirt and under an outer shirt or dress. Clothing worn over the prosthesis should be put on with the prosthesis arm going into the sleeve first and coming out last.

MAINTENANCE AND REPAIR

Even after good patterns of prosthesis wearing are established, periods of interrupted wearing due to need for repair or re-fabrication may result in lessened prosthesis acceptance and skill in use. It is therefore extremely important to anticipate outgrowth and keep the prosthesis comfortable, efficient and in good repair. Periods of interrupted wearing should be minimized or avoided. With some children such an inter-

Figure 5

Figure 6

ruption may be critical; even short periods of non-wearing may destroy a pattern which has taken months of work to build. With the child who has been a long-term wearer with firmly established wearing patterns an interruption may or may not be as critical to his acceptance. In general the purpose of fitting a prosthesis early is to build wearing habits that will stand the child in good stead through various future developmental phases.

Good maintenance of the prosthesis, like good wearing patterns, should be encouraged from the start. When a new prosthesis is delivered a series of tests are performed to check the workmanship, fit and function of the device. These tests (called the "checkout") have been recently adapted to children's prostheses and provide family, child and prosthetic team with assurance of a good child-machine combination. It is in the initial training period following checkout that the "trouble shooting" is done. The reliability and practicability of the mechanical components are evaluated and malfunctions or need for readjustment of harness or mechanism can be recognized and remedied.

The therapist can show the parents some of the simplest points of caring for the prosthesis but at the same time should stress the importance of returning to the prosthetist for repairs and adjustments requiring special skill. The orientation to mechanical parts, terminology and upkeep should be done slowly and deliberately, repeated by the therapist several times and then by the parent. This training process helps both child and parent take pride in the prosthesis and increases their motivation to learn how to use it well.

In the orientation period the parents should also gain an appreciation of what has gone into the designing of the arm and of the precise inter-relation of the various adjustments on the prosthesis. They should learn, for instance, that one-half inch difference in the harness adjustment can make a great deal of difference in ability to operate the controls. Thus they will become aware of the necessity of having some alterations made by a skilled prosthetist.

Following is a categorized list of maintenance and repair cues to guide therapists and parents in their work with the child amputee. Those adjustments listed under *"Maintenance"* may be made by the parents or therapist. Those listed under *"Repairs"* should be taken care of by the prosthetist.

PROSTHESIS

Socket Fit

Maintenance. Unsatisfactory socket fit is only one possible cause of discomfort for the amputee. The stump should be examined regularly; any areas of pus or skin breakdown or reddened areas at the bone tip should be reported to the physician. Bone overgrowth and skin rashes should be treated medically. The therapist or parent should keep fingernails or rudimentary finger buds well trimmed. Fit problems may also show up as follows: (a) the stump seeming to pop out of the socket frequently; (b) pain from forces exerted on the socket from any direction, or from actively operating the prosthesis (pushing into socket); and (c) marked discrepancy in length between the prosthetic and the sound arm. All these signs should be reported to the prosthetist so that he can make a socket adjustment or alert the prescription team to the fact that a new prosthesis is needed. If the child has excessive perspiration, or if there are suction noises when he pushes his arm into the socket, the prosthetist may need to add air holes to the socket.

Repairs. If redness is evident on the stump after removal of the prosthesis, this should be reported. If redness is localized to one spot, such as the socket trim line or bony prominence and discomfort is felt, it may have to be relieved by the prosthetist. Redness from a socket that is too small may be the first sign of outgrowth.

Friction

Maintenance. With friction-type wrist unit, the hook can be easily unscrewed from the wrist unit after the ball terminal of the cable has been disconnected. The friction here should be adjusted so that the hook can be turned easily with the sound hand, yet does not twirl involuntarily when tension is put on the cable. Adjustment of the wrist friction on the constant-friction type wrist units should be done with a screw driver only as needed. Manually operated friction components,

such as movable shoulder, or turntable, should be maintained at a level which is functional for the amputee. The child and therapist must determine the most desirable amount of friction in the training period. Usually the parts must be tight enough to stay in position during operation, yet loose enough to be easily manipulated by the child. If the therapist has the correct type of wrench to adjust the friction in the movable shoulder and turntable, he may do so as it becomes necessary.

Repairs. If the occupational therapist does not have the proper tools and knowledge of the prothesis construction to adjust the friction of the turntable, or shoulder, or washers to adjust the wrist friction, he should request that it be done on the next regular visit to the prosthetics clinic or sooner if the component is greatly out of adjustment.

Cleaning

Socket maintenance. The socket may be cleaned by using a washcloth with soap and water. It is important to do this frequently, especially if the child has been perspiring. Soap is best as detergents sometimes cause skin irritations. If a plastic friction material covers the socket, it may usually be cleaned with soap and water in the same way. The socket should be dried well before wearing. It is important that mechanical parts such as an elbow lock or metal hinges not be dipped into water. Prostheses should not be worn while bathing. It is not a good idea to oil or grease metal parts on the socket. These collect dirt and will cause these parts to become gummy. The leather cuff or leather hinges of the below elbow prosthesis may be wiped clean with a damp cloth since they have a plastic-type finish.

Repairs. Locks and hinges which need to be taken apart for cleaning should be brought to the attention of the prosthetist.

Hook maintenance. It is possible for dirt or sand to clog the bearings of a Dorrance hook. When this happens, the hook opens roughly or with difficulty even when all rubber bands are removed. The hook may not even close completely. To remedy this the hook may be removed from the prosthesis, rubber bands removed, and dipped into a mild solvent such as benzine or denatured alcohol, stud down, so that the liquid flows into the bearings. Manually working the hook open and shut should then loosen it. One drop of light oil may then be added to lubricate the bearings.

Repairs. If the hook is very badly clogged and simple washing as described above does not remedy it, it should be returned to the prosthetist for repair.

Terminal Device Lining

Maintenance. The rubber linings of the hook may peel with wear. Exposure to strong acids, lacquers and paints will also weaken the rubber, as may rough use in a metal shop. Some children also wear them out quickly with continued use on crutches or baseball bats. Unlined hooks or replaceable rubber tubing over hook fingers should be used if the child plans such activities often.

Repairs. Worn or peeling hook linings should be returned to the prosthetist who can send them to the factory to be revulcanized. Another hook can usually be loaned to the patient while this is being done.

Terminal Device Loading

Maintenance. The rubber bands which provide the prehension force on Dorrance voluntary-opening hooks should be changed as they wear out, rather than adding new ones on top of the old ones. The same amount of force should be provided after the change as the child had before. The bands may be cut into varying widths to provide fine degrees of adjustment. The degree of hook loading is determined by each child's needs and operating abilities. The loading should be strong enough to firmly hold objects usually desired by the child, yet not so strong as to require an undue amount of effort for opening the hook. Generally, the more loading the child can tolerate comfortably the more satisfactorily he will be able to accomplish tasks.

Repairs. Spring loading on Dorrance hooks are usually replaced by the prosthetist. It is important that only the prosthetist attempt to repair any mechanism in the Northrop Sierra (NS) two-load hook or Army Prosthetics Research Laboratory (APRL) hook.

Breakage

Maintenance. The hook should not be disassembled; that is, working mechanisms such as bearings and springs should be left intact. The child should be cautioned not to pry or hammer with the hook.

Repairs. When there is a breakdown in the basic mechanism of the hook it should be returned to the prosthetist for repair. Bent hook fingers should also be repaired or replaced by the prosthetist. The attention of the prosthetist should be called to: loose screws, sharp points inside the socket from rivets, broken or loose hinges, cracks or starved areas in the laminate, or sticky joints.

Covering

Maintenance. The poly-vinyl-chloride covering (PVC) used in the socket sleeve of gauntlets, for covering the infant hooks, and for gloves of infant hands, as well as the adult APRL cosmetic blove, are permanently soiled by such things as ballpoint ink, newsprint, smoke and such. The care of this material is explained in a printed sheet available from the Kingsley Co., Placentia, California.[4]

Repairs. Severely torn, discolored, or stained coverings and gloves that cannot be cleaned in the ordinary ways may need to be replaced by the prosthetist. Hooks with torn or worn through coverings may need to be returned to the factory to be re-dipped.

Added Equipment

Maintenance. Therapists should be aware of new equipment which may be of assistance to the child in his activities as it becomes available. New hook lining which does not mark paper or new hook types are examples of this. Simple adaptations may be needed such as a piece of rubber tubing which may be placed on the stationary hook finger for friction, or a friction gauntlet sleeve of PVC or leather skiver which may be placed on the forearm socket. If either of these should tear or pull off, a new one can be put on by the therapist, parent or prosthetist. The therapist should be alert to the functional needs of the child so he can make suggestions for modifications or new components as needed. Small parts, such as the cable adapters which are used by older children who may have both a hook and a hand, should be kept with their terminal device to avoid their being lost. It is wise to secure them into the thumb of the hook with a graumet.

Harness Alteration

Maintenance. The harness is constructed to meet certain specific requirements in function and fit. It is therefore extremely important that it not be altered except by the prosthetist. Harnesses which snap or buckle onto the prosthesis are often made of Dacron (white) or Vinyon (yellow) and are washable. Children should be given two with each prosthesis. The parents or child learns how to interchange the harnesses on the prosthesis during the initial training period. Thus, one harness can be washed while the other is being worn. Snaps should work smoothly and not be extremely tight. A drop of light oil on the snap will keep it working easily. If the tips of the harness strap become worn or begin to ravel, they may be singed with a match flame to seal the edges.

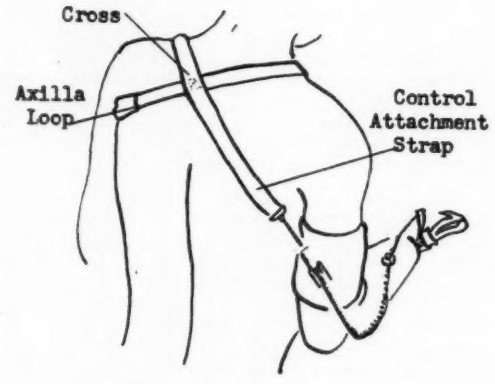

Figure 7
Rear View, Harness for Below-Elbow Prosthesis

Cross

Maintenance. The figure-of-eight harness is stitched where the straps cross in the back. It is desirable that this be below the seventh cervical vertebra and slightly to the unamputated side (See Figure 7).

However, on a very young child or one with poorly developed shoulders it may be impossible to prevent the harness riding high on the back of the neck.

Repairs. If the cross on the figure-of-eight harness rides excessively high or pinches or binds the neck, it should be referred to the prosthetist for an adjustment.

Axilla Loop

Maintenance. The axilla loop may appear tight, but it must necessarily fit closely. The child may find his axilla sore at first, but this soreness will diminish as the skin toughens with continued wearing and use.

Repairs. If discomfort in the axilla area is severe and perisistent it should be called to the attention of the prosthetist.

Control Strap

Maintenance. The adjustment of the control attachment strap (CAS), (Figure 7), which rides across the back just below mid-scapular level, should be marked or stitched into place by the prosthetist after the correct adjustment is determined. This adjustment should be left as set or replaced at the same point after each washing. As the child outgrows this adjustment, he may find it increasingly difficult to keep from maintaining tension on the cable. Ideally the child should be able to keep the hook closed with the forearm in extension and the hook in full pronation, and still not use excessively gross motions to operate the device. If he cannot do this it may need to be called to the attention of the prosthetist since it may be either the control strap or the cable length itself which needs adjustment.

Repairs. The control strap should be altered only by the prosthetist. Alteration of any harness strap affects the adjustment of others and therefore all harness changes should be made by the prosthetist.

Front Support Strap

Repairs. Infants may have some difficulty in keeping the front support strap from riding back over the shoulder because of their rounded contours and gross body movements. If continuous slipping back occurs the prosthetist may need to add a strap across the chest from the axilla loop to the front support strap.

Elbow Locking Billet

Maintenance. In an above-elbow type of prosthesis, there is an adjustable elbow-lock billet (ELB), (Figure 8), attached to the elbow-locking cable. This rides next to the elastic front suspensor (ES) in the delto-pectoral triangle. The adjustment of this billet is critical to effective use of the elbow lock. If it is too tight the elbow will unlock involuntarily, and much forward motion will be needed to allow for the return phase of the lock. If it is too loose, the amputee must use a very gross motion to perform the locking and unlocking. This adjustment often needs to be determined in the training period with a child who is just learning this control. Once an optimum adjustment is found, it should be marked or stitched.

Repairs. Adjustments to the elbow-locking billet after it has been stitched may be made at the suggestion of the therapist, but should be done in cooperation with the prosthetist.

CABLE

Removal-Replacement

Maintenance. Regular maintenance of the control system is important. If the ball terminal of the cable falls out of the thumb lever even the child may be taught to replace it (Figure 9). If the retainer falls out of the base plate it should be replaced. The cross bar

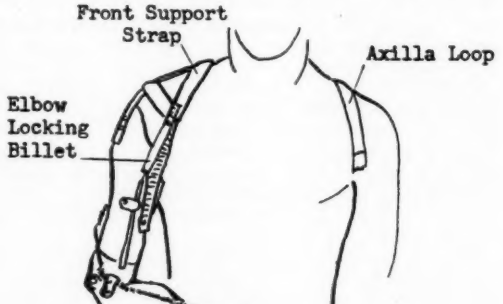

Figure 8
Front View, Figure-of-Eight Harness for Above-Elbow Amputee

should be replaced in the leather retainer on the cuff if it falls out. Also, replace the control strap of the harness in the T-bar hanger. The above four steps also allow complete removable of the cable assembly for the insertion of a spare or new cable in the standard below-elbow types of prostheses.

The cable may be removed from an above-elbow prosthesis by removing the ball terminal from the thumb of the hook, unscrewing the leather lift loop from the forearm socket being careful to leave the cable housing tightly within it, removing the key from the proximal retainer plate and the hanger from the harness strap.

Repairs. If the ball terminal or the retainer fall out continuously, the prosthetist or therapist should be told, so that he can put a graumet on the ball terminal and a rubber disc in the base plate.

Breakage

Maintenance. Some warning signs that the cable may soon need some attention are: (a) frayed cable, (b) sharp bend in the cable—it may fray at this point, (c) excessive friction in cable pull—nylon liner (if used) in the cable housing may be broken or full of dirt, (d) cable housing catching under elbow hinge and limiting forearm flexion—the distance between the retainers may need to be altered, (e) pinching of the skin by the cable—wearing a T-shirt under the prosthesis

may solve this problem, or the cable length may need to be altered by the prosthetist.

Repairs. No soldering or other cable repairs should be attempted except by the prosthetist. If the cable breaks and the child is unable to come to the prosthetist the cable assembly may be removed as described above under "Maintenance" and sent to the prosthetist for repair and a spare cable put on. If measurements are made to send to the prosthetist so that he may replace a Bowden cable, they should include:

1. Distance from ball terminal to T-bar hanger—(total length)
2. Length of cable housing—(total length)
3. Distance between distal and proximal retainers on the housing and distance from ends of housing.

For a cable on an above-elbow prosthesis measure:

1. Distance from ball terminal to T-bar hanger—(total length)
2. Length of distal piece of cable housing and distance from end of housing to leather lift loop.
3. Length of proximal piece of housing and distance from end of housing to retainer key (if more than one retainer key is used, their placement must be indicated in the measurements)

Contemplation of the foregoing list may lead one to question the practicality of prosthesis fitting for children. They play in sand, dirt, and water and engage in rough sports as a part of their everyday lives. Yet the number of major breakdowns seen in prostheses due to such causes is surprisingly small. A detailed account of the types and frequencies of these problems is being kept by the prosthetist of the child amputee prosthetics project in order to document them more accurately. Keen awareness of the finer points of good maintenance and observation of these on a regular and frequent basis by the therapist and family can often make the difference between a prosthesis which functions well and one which does not.

The child wearing the prosthesis can also be made aware of the need to keep it in good working order. This does not mean that he should over-protect the prosthesis and curtail his activities. Judgement should be used in directing the play of the amputee child since he should be cautioned against careless destruction, i.e., using his hook as a hammer, yet encouraged to participate in play activities usual for his age, and include the prosthesis in these in a normal manner. He should not be afraid to play in the sand or dirt, but his parents should then check his hook to be sure it is cleaned when indicated. The boy who climbs trees should not be asked to remove his prosthesis for fear he will break a cable, but should be given a spare cable initially as part of his regular equipment. He can then replace the spare cable if and when it breaks and send the broken one to the prosthetist for repair.

Current developments in prosthetic components for children have stressed the functional needs of children as an important criterion in their design. The prosthesis must be made to meet the needs of the child, not the child made to adapt to the prosthesis.

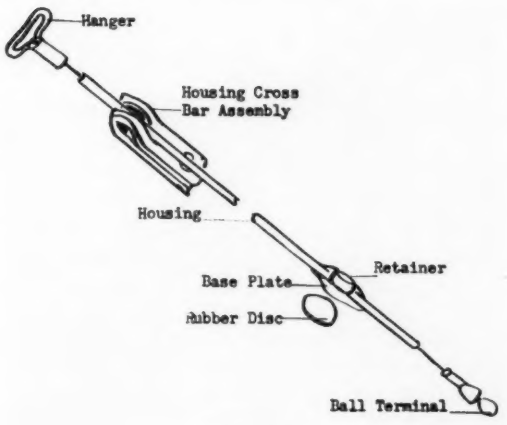

Figure 9

Cable Assembly for Below-Elbow Prostheses

The descriptions in this article have all referred to currently available equipment. It is anticipated that new equipment developed specifically for the unique needs of children will not only make them easier to care for, but will provide greater function for the child.

The importance of good family orientation to the prosthesis cannot be over-stressed. Their positive attitudes toward the child's wearing of the prosthesis, maintaining it in good working order, and cooperating with the training procedures, form the foundation of the program. The initial training period is an important time for orienting the family to their role and giving the child a good start in becoming a skillful prosthesis user.

The initial training plan should be carefully outlined for the family. It should be a formalized plan which states the frequency, length and aims of the training program. Along with the orientation described above, the initial training program includes the learning of prosthetic controls and an introduction to prosthetically oriented activities. The child is introduced to his prosthesis through the medium he understands best—play. This play under the therapist's direction helps the child learn correct control operations and see the potential uses of his new prosthesis.

Learning new skills or re-learning old skills in a new way requires much guided practice and repetition before a habit pattern is formed. All of this cannot be done in the training room in an initial period. Good carry-over into the home

(*Continued on page 26*)

AN ARM-GUIDE FOR THE ATHETOID

MARGARET E. ALDERMAN, O.T.R.*

Persistent abduction and rotation of the humeri pose a constant problem in the treatment of the athetoid.[1,2] With the more severe handicaps of this type only a few very simple activities are possible in the occupational therapy program. More complicated skills are applicable only when a greater degree of shoulder control has been effected, and the hands are brought into a working position.[1] Methods of developing this control are distinguished by: (1) the use of appliances to hold the upper extremity in position: e.g., bracing, upper-arm restraints, sand-bags or wrislets,[3,4,5] and (2) achieving relaxation and voluntary control without the use of appliances.[6,4,1,7] Experience in the administration of the various methods suggests that they are not always completely effective or practical in the treatment of the preschool cerebral palsied child.

PRESENT METHODS

There are many types of appliances, some partially effective, most with at least one distinct disadvantage. The *upper-arm restrainer* made of two-inch webbing looped around the arm and buckled into position is likely to cause friction sores or to shift position due to the constant movement. The more encompassing, *sleeve-type model* may cause discomfort or even painful muscle spasms because of its inflexibility; it is also awkward and time consuming to apply. While these two types control abduction, they do not always control rotation, and the hands still do not meet in a practical medial position.[1] *Sandbags* may be useful in restraining the sub-dominant arm during mono-manual play, but they offer no direct control of the dominant extremity. They may be helpful for bimanual skills requiring fairly fine coordination but are useless for those requiring gross coordination. *Wristlets* effectively decrease extraneous motion, particularly in the mild handicaps. However, they exercise insufficient control for any real value to the more severe handicap unless additional control is applied to the proximal joints.

If appliances are not used then active control must be achieved through voluntary efforts. Working from relaxation to purposeful movement, proximal to distal, means that several years may elapse before progress reaches beyond the first joint—the shoulder. In the meantime the distal parts may become weak, atrophied, or may form poor patterns of movement which must eventually be undone.[7] Another important point to consider is that maximum habilitation comes through early treatment. Attention span at this preschool age is comparatively short in a normal child, and is often shorter in a cerebral palsied child. With the physical handicap added to the short attention span the number of suitable activities is small and the child tires of the same few games month after month, and year after year. Motivation becomes a problem, particularly in the child with normal intelligence who needs more stimulation.

Because of the shortcomings of present methods of handling the athetoid, a guiding-type apparatus was devised by the author for use at the Spastic Children's Clinic and Preschool. This "arm-guide" offers a compromise between the use of appliances on the one hand, and no controls on the other.

CONSTRUCTION

The construction of the arm-giudes is not only simple but also economical; a pair can be assembled in about an hour at an approximate cost of $2.30. This one set can be used for all children within the preschool level, and possibly for many beyond this age.

LIST OF MATERIALS

Four pieces three-fourths inch plywood, ten by twelve inches	$ .75
Four corner braces	.20
Two pieces foam-rubber, ten and one-half inches by thirteen inches	.55
Two pieces cloth-backed plastic, thirteen inches by fifteen inches	.60
Upholstery tacks	.10
Total	$2.30

Nails
Two four inch C-clamps

Materials are assembled in the order presented; two pieces of plywood are nailed at right-angles along the 12 inch side, and reenforced with a corner brace at each end. One outer surface is padded with foam-rubber and covered with plastic, both of which are carried over the cut edge of the wood and secured with upholstery tacks; this padding eliminates the possibility of scratching and bruising. The bare wood may be finished with varnish.

APPLICATION

The child is seated securely at a cut-out table which is elbow height and about thirty inches square. It may be necessary to use some type

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Figure 1. Arms are confined to a fairly large area for finger-painting, yet they do not flail out in space.

Figure 3. The patient is able to remove and replace the pegs since the proximal joints are controlled by the arm-guides.

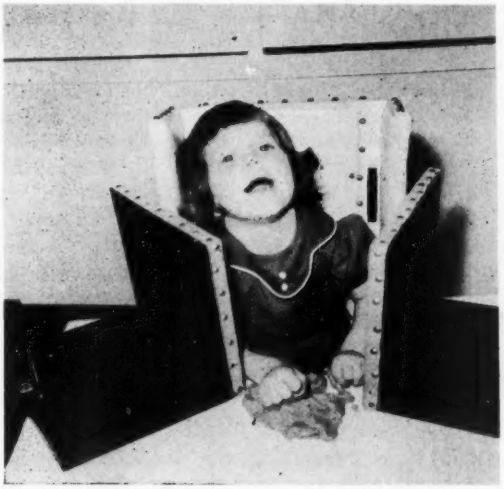

Figure 2. The arm guides are placed medially for working with Play-dough.

Figure 4. The patient successfully eats a "sucker" with the arms held in adduction.

of fastening to keep the chair near the table if the child is inclined to push away from the table. With wood side down, and padded sides facing, the arm guides are clamped to the sides of the table, the child's arms in between. The exact position is determined by the activity at hand and the therapeutic needs of the child. For finger-painting they should be about ten inches apart (Figure 1), for Play-dough, only six inches (Figure 2). The angle of the guides is determined by the physical needs of the child: e.g., closer together at the near end for greater adduction; slanted inward at the far end for greater internal rotation.

The size of the arm-guides can be adjusted according to the size of the child. They should stand just above shoulder height so that the arms do not flail over the top. Ten inches seems to be a useful height for most preschool age children. Sand-bags or wristlets may be used in conjunction with the arm-guides if greater stability is indicated.

ADVANTAGES

The arm guides are designed to confine the arms to a limited range of motion. By guiding rather than restraining, the patient is motivated to develop active control of the shoulder joint, and at the same time he gains experience in the function of the distal parts. The child comes to know and feel the normal working attitude of the upper extremities and to perform in this position—humeri adducted and internally rotated,

and elbow flexed. Due to this limitation of movement of the proximal joints he is capable of finer coordination (Figure 3) and bimanual skills. A whole new world opens up to him in the form of a much wider range of activities. With the child's capacity increased in this manner the problem of motivation, attributed to short attention span and long range treatment, is vastly minimized.

Another advantage of the arm-guides is in their adaptability. They are adaptable to the child, to the handicap and to the activity. As previously mentioned this apparatus is applicable to all ages and sizes within the preschool level and although it has not been tried would probably do for an even older age group. The degree and type of handicap are accommodated by moving the guides medially for increased adduction, and laterally for increased abduction; rotating outward for increased external rotation, and inward for inward rotation. They have been useful, in some cases, for types of cerebral palsy other than athetosis, but have been used mostly for the one category. After experiencing the more normal range of motion, a child is able to hold this position for increasing lengths of time after the arm-guides are removed.

The economical advantages of the arm-guides have already been pointed out in terms of cost and in terms of adaptability to the wide age range. Since most types of appliances must be custom made for each individual child these are also economical from the standpoint of time —the difference between making an appliance for each child and making one set of arm-guides for all children.

Still another advantage lies in the possibility of earlier hand-to-mouth training. The modified control allows the arms to operate in a fairly normal pattern of movement within the confines of the apparatus (Figure 4). Without the proximal limitations, hand-to-mouth training would not be feasible until the patient developed a sufficient degree of strength and coordination to be independent in feeding skills. *Precaution*: It should be understood that the arm-guides are not intended to replace more active therapy to strengthen shoulder adductors and rotators. They simply serve to facilitate coordination of the total extremity during the long years of treatment in conjunction with more direct methods of developing these muscle groups.

SUMMARY

Many methods of treatment have been tried in an attempt to plan an adequate program for the athetoid cerebral palsied child; experimentation is still going on. The disadvantages of present methods led to a search for something new and different; the idea of the arm-guide seemed reasonable. With these guides, rather than restraints, the arms would be confined to a limited range of motion instead of being completely immobilized or being allowed full range of motion where poor attitudes for the extremities might become habit. The results of a year's trial period of using this method reveals the following advantages: construction is simple, quick and inexpensive. One set accommodates a wide age range. They can be adjusted to child, handicap and activity. An increased number of activities becomes available to the child. Motivation for active control is increased. Hand-to-mouth training is possible at an earlier date.

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Child Amputee . . .

(*Continued from page* 23)

and/or by a therapist in the child's community is essential until a strong and consistent pattern of wearing, control, and use has been established. Shortcuts in any part of the plan have proven unwise to the long term prosthetic program. With good initial family and child evaluation, fitting, training (as described) and follow-up, we can expect good results in fitting the child amputee.

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NATIONALLY SPEAKING

From the President

At the highly successful annual conference of the American Occupational Therapy Association in Chicago last October, a second joint meeting of the Board of Management and the House of Delegates was held. A full report of this has gone to each delegate to be presented to the individual state associations. Some of you, however, may not have been able to attend the meeting of your association at which your delegate's report was given. Therefore, in order that you may have the fullest possible information, I am presenting a brief resume and some further facts which I hope will be of interest and value to you.

The meeting was more structured than the one held in Indianapolis last April. A committee headed by Miss Marjorie Holtom carefully planned a program of presentations related to the organization of the Association. The following topics were covered: 1. "Role and Function of State Associations," Miss Florence Stattel, 2nd vice-president; 2. "The Structure and Function of the House of Delegates," Miss Ethel Huebner, speaker of the House; 3. "The Structure of the Board of Management and the Function of the Association's Committees," Miss Helen S. Willard, president; 4. "The Role of the Executive Committee," Miss Beatrice Wade, 1st vice-president; 5. "The Role of the National Office and the Executive Director," Miss Wilma West, treasurer. Miss West's presentation was most effective with a series of colored slides showing the personnel and activities of the office. These are available for any group which may wish to use them.

After these presentations questions were addressed to the various speakers. These brought out the facts that the executive committee, made up of the president, one vice-president, the treasurer, and four members of the Board of Management, one of whom (usually the speaker) is a member of the House of Delegates serving on the Board, considers all matters related to the finances of the Association—budget, salary reviews, dues, new projects and their costs, etc.) It also considers personnel policies, selection of personnel subject to Board approval, review of recommendations for awards of merit, grants, their acceptance and/or operation because of financial and personnel overtones, and determination of dates of the annual conference. The committee makes recommendations which are referred only to the Board which in turn may refer them to the House of Delegates for consideration and/or transmission to the membership. Actual policies which affect the membership are not fully established until they have been approved by the majority of state associations whose opinions have been transmitted through the House to the Board. There are, therefore, clearly established lines of procedure through which actions have to be taken.

It was suggested that the size of the Board should be reduced so that it might function more efficiently. Its present size (23 members) was established in order to give geographic and area representation. It is out of balance because the places filled for some years by the Fellows (now replaced by the Medical Advisory Committee) have been filled by therapists at large. It may be advisable to more nearly equalize the number of delegate Board members and therapists at large and let geographic and area representation be covered by the House. This is a subject for careful consideration and discussion.

It was definitely emphasized that the actions of the Board are not secret. Minutes are sent to all delegates and are published in AJOT. It is the duty of the delegate Board members to vote as a block through the speaker on matters on which the House was voted or recommended certain action. On other matters discussed by the Board it is the delegate Board member's responsibility to express his own opinion and to vote according to his own convictions. The Speaker and all delegate Board members are responsible for reporting actions of the Board to the House and thus to the membership.

The question was also asked as to how often the executive director is able to visit state associations. The answer was "Not often enough." At the present time, we do not have enough money or personnel to make frequent trips. Many visits have been made within the past year by the executive and assistant executive director, members of the education office, the rehabilitation consultant and the members of the curriculum survey team. The officers endeavor to contact as many members as possible. A request from state associations for such visits will be met as extensively as time, pressure of work and money permit. Any urgent matter can always have attention.

The remainder of the meeting was a free discussion period with Colonel Robinson in the chair. Two questions were posed: 1. Have the AOTA Boards, previous and present, tended to accept executive or committee recommendations without discussion and questioning, thus avoiding the responsibility for a decision? 2. Have AOTA Boards made decisions without reference to the national office staff and/or have they

accepted recommendations from the national staff without adequate considerations?

These questions obviously arose because of the problem of the relocation of the national office and the membership feeling about the postponement of action on the move.

In brief, the answers made were that the Board has not evaded responsibility for decisions made. The time given to consideration of matters brought up is absolutely unpredictable. One recommendation or report may be very quickly acted upon whereas the next may provoke hours of discussion. Decisions are made by the whole group. Any member who disagrees or disapproves is obligated to so express himself at the time or to accept the decision of the majority.

The national office is in many cases responsible for implementing decisions. The Board, therefore, consults with the executive director and the staff in regard to the practical problems of processing and implementation. However, as in the case of the reversal of opinion of the special committee, appointed to implement the move to Chicago, the material which caused their action was not collected by the national office staff but by a wide spread, representative group of persons, many of whom were actively in favor of the move.

The original recommendation regarding the move had the modifying clause "if this appears best for the functioning of the Association," and the Board accepted the recommendation on that basis.

It was agreed that the office should move in 1949. Reference to the minutes of the Board in the fall of 1948 (AJOT, Vol. III, P. 54) show that the Association did not have sufficient funds on hand to pay the national office salaries from September through December. A change of billing time helped to correct this situation and a later increase in dues provided some additional funds but for several years the Association operated on a very stringent budget. It was ascertained that it would cost as much or more to operate in Chicago; therefore, any plans to move were held in abeyance as the cost would have seriously handicapped the functioning of the Association.

From 1949 to 1954 there is no mention of the move in the minutes of either the Board or the House of Delegates. During this period there was tremendously increased activity but also increased need of funds. Some of the developments were as follows: grants were obtained for the establishment of our education office but means had to be found for supporting it after the grants ceased. We took over the publication of our own magazine (AJOT) and it was three years before it broke even and began to pay for itself. Our national office salaries were so low that it was difficult to attract the highly qualified personnel whom we needed save for those who were sufficiently interested to accept the financial sacrifice and undertake the excessive amount of work involved. Finally there seemed no adequate space obtainable within our means in Chicago.

During this time we learned of the proposed new building of the American Hospital Association in Chicago. Our executive director kept in touch with the plans and in 1954 negotiations were begun in regard to the move, which as you know, ended in 1959 with the information that no space would be available for us because of the changed plans of the Hospital Association.

Investigation of costs as they were ascertained by the special committee to implement the move proved to be massive in loss of personnel in the national office staff who were willing but unable for personal reasons to go to Chicago. In actual dollars and cents the cost was estimated at a minimum of $12,000 and a mean or average of $28,000. Operating costs would be equal or higher.

The Association has just reached a point where it is able to pay more adequate salaries and can send representatives farther afield. Some assistance can now be given to committee members. The Speaker of the House now receives re-imbursement for full expenses but no other officers do as yet.

I hope that this report may have given further clarification so that at our next joint meeting, which may well be a full session at the next conference, we may have increased evidence of the greater understanding and spirit of interest and friendly cooperation which was so strongly felt at the Chicago conference.

Helen S. Willard, O.T.R.
President

From the International Committee

We find ourselves in a world no longer confined to national boundaries, but one in which communication and the exchange of information and resources is possible with all countries—we are truly a part of a rapidly developing and expanding international age. It is an exciting and challenging era that makes it possible for us to visit, to learn from, and to work side by side with occupational therapists in many countries of the world, and to welcome to our shores visitors from these countries.

The personal and professional benefits of such exchanges are unlimited, but they also imply

many obligations that we must each identify for ourselves and acknowledge. Whether at home or abroad, in our contacts with other nationals, it behooves us to remember that we represent not only ourselves and our profession, but equally as important, our countries and our culture. Our actions, be they acceptable or unacceptable, create a picture for the observer of what kind of people Americans are. Let us think twice and be sure to paint a picture of the United States people and of our way of life that we can be proud of.

In October of 1962, we will be hosts to occupational therapists from around the world when the third international congress of the World Federation of Occupational Therapists convenes in Philadelphia. We hope many will visit us, bringing the benefit of their knowledge and experience to us, as well as their interest in observing our methods. Some will be visiting our hospitals, schools, and treatment clinics both before and after the congress; some may come to work with us for awhile. We should begin preparing to greet our visitors by reinforcing our knowledge about their countries, particularly the member countries of the World Federation of Occupational Therapists.

Our occupational therapy international activities are spearheaded by the World Federation of Occupational Therapists and implemented in the United States through the international committee of the American Occupational Therapy Association. Our obligations in the international sphere became more intensified in January, 1959, when the World Health Organization accepted the World Federation of Occupational Therapists for official relations as a non-governmental organization, making an acknowledged contribution to the health of the world's people.

The World Federation of Occupational Therapists is in an official position which requires, among other things, that we be prepared to offer consultative and other services to other countries on request, to prepare interpretive exhibits about occupational therapy, and to send our representatives to the general assembly and regional meetings of the World Health Organization. The only channel available to the World Federation of Occupational Therapists for obtaining the necessary funds to meet these obligations, particularly representation at meetings of the World Health Organization, is through membership dues. In a recent American Occupational Therapy Association *Newsletter* you received a World Federation of Occupational Therapists membership application form. If you have not had an opportunity to fill it out or have been undecided about membership, won't you give it a second thought?

The international committee of the American Occupational Therapy Association is concerned with: (1) developing interest in the international activities of the American Occupational Therapy Association, (2) developing increased support of the World Federation of Occupational Therapists through individual membership, (3) formulating policies and channels for the occupational therapy professional activity of visitors to the United States from other countries, (4) developing mechanics and channels for the professional activities of United States therapists in other countries, and (5) assisting with World Federation of Occupational Therapists projects as, collecting slides, pictures and visual aids for use by the World Federation in preparing interpretive material.

To accompish these objectives, assistance is needed from all of our members, and we ask that you carefully consider the following questions to see if you can contribute to any of them:

Are you a member of the World Federation of Occupational Therapists? Why not send in your application to the American Occupational Therapy Association office today?

Have you occupational therapists from other countries working in or visiting your department? Please notify the American Occupational Therapy Association of such visitors to permit the establishment of a central registry of all overseas visitors in the country. It would be appreciated if you would help keep this information current and up-to-date.

Do you advise overseas visitors in your department about the American Occupational Therapy Association requirements for registration? Obtain for your own information a copy of the requirements and advise the therapist to contact Miss Viriginia Kilburn in the education office of the American Occupational Therapy Association as soon as possible for additional information. Correct information and careful guidance of our visitors in planning their professional programs cannot be overstressed. If you do not have the information, be sure to refer to those who have.

Do you have available 35mm colored treatment slides or black and white 8"x10" treatment photographs that you would be willing to contribute to the World Federation of Occupational Therapists' exhibit? If so, kindly contact Miss Cecilia Sattely, O.T.R., Chief Occupational Therapist, Veterans Administration Hospital, 130 West Kingsbridge Road, Bronx, New York.

Do you meet qualifications for and would you be interested in serving as an expert advisor for the World Federation of Occupational Therapists? Your application is invited as described in the *Newsletters* of June, 1959, and January, 1960.

Should you be selected for such service, your invitation to participate would reach you several months before the beginning of the project, giving you ample time to make personal and professional arrangements to be away.

These, then, are some of the specific ways in which we as individual occupational therapists can establish professional bonds across national boundaries and work for improved health, better understanding, friendship and peace in the troubled world of today.

Marie Louise Franciscus, O.T.R.
Chairman,
International Committee

From the WMHY Delegate

The twelfth annual meeting of the World Federation for Mental Health was held in Barcelona, Spain, from August 31 to September 4, 1959, at the University of Barcelona Law School. I was the only occupational therapist there, most of the participants being psychiatrists, psychologists, psychiatric social workers, nurses and clergymen. The theme of the conference was "Planning for Mental Health," and the five plenary sessions were designed to support the project activities of the World Mental Health Year (WMHY) in 1960.

At the opening session, Dr. Hans Hoff of Vienna, president, outlined the mental health movement from its earliest beginnings, mentioning the contributions made by occupational therapy under the direction of Connolly in England and Vincenzo Chiarugi in Italy. Indeed, during the whole conference there was mention of occupational therapy in an intelligent, thoughtful, knowledgeable manner.

Dr. Leo Bartemeir of the U.S.A. gave a very concrete presentation of developments in the United States, stating that the concept of a psychiatric hospital as a part of the community is emerging and becoming in many instances a reality by the development of psychiatric units in general hospitals. He maintained that the ultimate possibilities of reducing the incidence of mental disorder may be found in the future preparation of general practitioners in psychiatric detection, and also the development of an infinitely larger number of professional personnel in the paramedical disciplines. He stated that today we were prepared to treat the mentally ill but not to prevent mental illness.

Prof. Juan Bosch Marin of Spain, in his discussion on the development of the child, brought out the important point that we should discover not only what is dangerous to the child but what benefits him as well. For example, he mentioned that very often children who live in a precarious home situation develop very well because of some benefits that exist even in an adverse situation. He emphasized that we must teach children to grow in mental strength so that when adversity comes they will be able to deal with it.

Prof. Carson Ryan of the U.S.A. stressed in the session on "Mental Health in Professional Education" how we must have a more careful selection of candidates in our medical and medical auxiliary schools. He suggested that there there should be more in-service training with early patient-practice in our universities and that mental health training should start much earlier in the university course.

The subject "Mental Health and Migration" was examined by Dr. Hans Strotzka of Vienna. He used the word migration to include the following circumstances: (a) political flight and expulsion, (b) tendency of workers to leave the country for the city or vice versa, (c) migratory labor and (d) commuting (at daily, weekly or monthly intervals). The speaker maintained that for the psychiatrist this sociological concept of migration is of great importance because nearly all studies on this subject agree that migrants are exposed to much greater hazards to their mental health than are the inhabitants in their country of origin. It was suggested that special training in the problems of migrants should be given. Dr. Strotzka terminated by saying that excessive conformity within a culture may be a sign of psychological disturbance.

On the last day of the conference there was a general session at which plans, policies and possibilities of the WFMH were presented by the director, Dr. J. R. Rees of England. He proposed that in each country those professional associations which belong to the National Mental Health Association should make suggestions to their specific association as to projects which they could undertake in a joint effort for World Mental Health Year. These proposals should be communicated to the National Association for Mental Health in the United States. Already two qualified social workers in the U.S. have offered to give two full days a week of professional service gratis to WMHY. In addition, the American Association on Mental Deficiency has decided to recommend to their council that the theme of World Mental Health Year be used for their 1960 convention and also that the association should undertake a special study of some aspects of mental retardation as their contribution to WMHY. At a meeting of the chief delegates from the United States which I attended, I was asked what the American

Occupational Therapy Association had planned as their special project.

Those attending the conference were allocated to discussion groups of five to fifteen persons, each related to one of the five special sections of WMHY. These discussion groups met for six one-hour sessions and made a report to the coordinator for World Mental Health Year. I worked with the group "Mental Health and Professional Education." One of the main problems discussed was that of student selection in the various disciplines represented. It should be mentioned that the WFMH is now compiling papers relative to selection procedures for people serving in international agencies or going on overseas missions. The group for the advancement of psychiatry already has published a report (No. 41) entitled "Working Abroad, a Discussion of Psychological Attitudes and Adaptations in New Situations." Since there appears to be an increasing number of occupational therapists working overseas, it might be suggested that the Association consider this material.

At the business meeting the results of the election were announced: President, Dr. Paul Sivadon (France); Vice-President, Dr. A. C. Pacheco e Silva (Brazil); Treasurer, Dr. George S. Stevenson (U.S.A.). The next two annual meetings of the WFMH will be held in Edinburgh, August 7-12, 1960, and in Paris August 30-September 5, 1961.

Respectfully submitted,
Anne Nicholson Turchi, O.T.R.
Delegate

ELIGIBILITY FOR WRITING THE EXAMINATION FOR REGISTRATION*

The registration examination of the American Occupational Therapy Association is administered semi-annually in January and June. For information regarding method of application, fees and places where the examination will be held, prospective applicants from abroad should apply to the director of education of the Association six months prior to the date of the examination. It is recommended that advice and guidance be sought prior to coming to or on arrival in the United States of America.

Applicants for the examination must meet the qualifications in either Section I, II or III as outlined below.

I. Graduation from a curriculum of occupational therapy approved by the American Medical Association and the American Occupational Therapy Association

II. Graduation from a curriculum of occupational therapy approved by a member association of the World Federation of Occupational Therapists. The applicant must meet the following requirements
   A. Be recommended by the director of his occupational therapy curriculum
   B. Be a member in good standing of his national occupational therapy association
   C. Qualify within one of the following categories
      1. *Student therapist*: one who is enrolled in the clinical affiliation program of an approved occupational therapy curriculum in the U. S. A. and who meets the following requirement
         Successful completion of a minimum of 9 months' clinical experience in the U. S. A.
         (1) Experience secured at various affiliation centers in accordance with the American Medical Association *Essentials*
         (2) Clinical affiliation reports submitted by the supervisor(s) as for regular students
      2. *Post-graduate therapist*: one who has taken advanced study in the U. S. A. in a program planned by (1) the director of an approved occupational therapy curriculum or (2) an official governmental or non-governmental organization. It is suggested that the therapist and the sponsoring organization contact the American Occupational Therapy Association in order that the following requirement may be clearly understood
         Nine months' experience in the U. S. A. under the supervision of registered occupational therapists
         (1) Experience secured in periods of two months or more. Two months may be used for special study and/or observation
         (2) Clinical affiliation or work performance reports submitted by the supervisor for each affiliation or assignment
      3. *Employed occupational therapist*: one employed in the U. S. A. or elsewhere and who meets the following requirement
         Successful completion of nine months' work experience in *one* occupational therapy program under the supervision of occupational therapist(s) registered with the American Occupational Therapy Association
         (1) Work record reports submitted by the supervisor(s)
         (2) Recommendation of the supervising occupational therapist(s)
   D. Special exceptions to the requirements set forth in this section (II) may be made on an individual basis by the registration committee of the American Occupational Therapy Association for an experienced occupational therapist

III. Occupational therapists from countries lacking (1) a national occupational therapy association, (2) a formal occupational therapy curriculum will be admitted to the examination under the following conditions
   A. Eligibility to write the registration examination shall be determined for each individual by the registration committee on the basis of the applicant's educational and practical experience
   B. In no case shall the applicant's clinical or work experience be less than that required under any one of the categories in Section II above

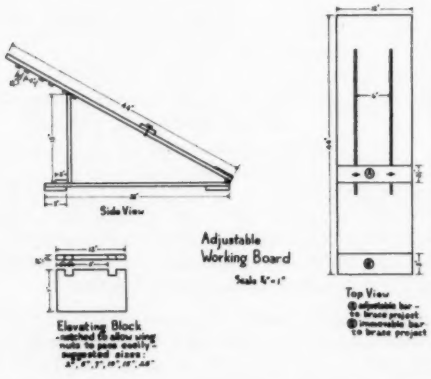
*This eligibility statement supercedes the previous "International Reciprocity Policy" adopted in 1957 and was approved by the Board of Management of AOTA, October, 1959.

Picture Page

*Portable Feeder**

A portable feeder which can be raised or lowered for individual use. It is easily attached to a table or wheelchair without scratching the surface. It is recommended for home use because of the ease of setting up which requires no aid from others.

Adjustable Work Board†

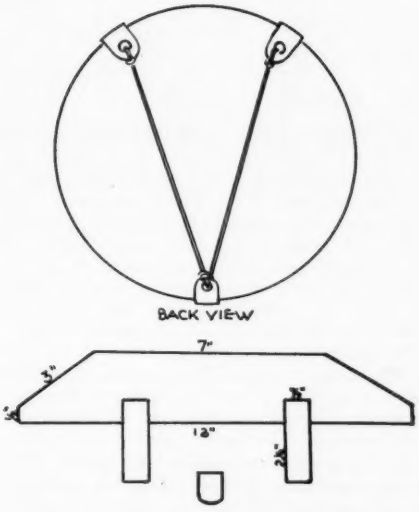


Angle of the working surface adjustable for flexion and extension of the forearm and flexion and extension of the arm.

*Occupational Therapy Section, V. A. Center, Los Angeles, California
†U. S. Army photograph, Madigan Army Hospital, Tacoma, Wash.

Picture Page

*Plate Guard**



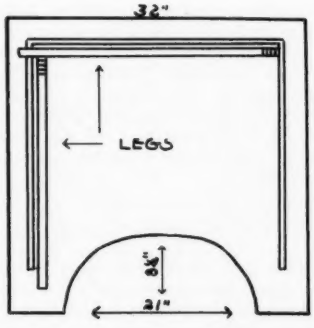
Materials

16 gauge aluminum, 24 ST 3 (alloy temper)
- 1 piece 2¾ by 12 inches
- 2 pieces ½ by 2½ inches
- 1 piece ½ by 1 inch

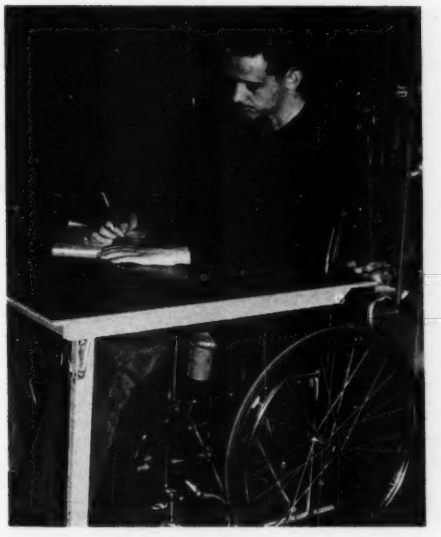
2 aluminum rivets, ¼ inch
3 aluminum eyelets, ¼ inch
3 rubber bands

Cost: approximately $.35.

Guard to be used by handicapped person to push against when loading spoon-fork with food. It is very stable and easily fitted to any plate size. Rubber bands act as stabilizer for the plate. The type of construction makes economical use of materials and pieces of aluminum may be quickly cut in strips with metal shears, saving time in construction.



*Folding-Leg Lapboard**



Materials

Plywood
- 1 piece 32 by 32 by ½ inches
- 2 pieces 29 and ½ by 1 and ½ by ¾ inches (legs)
- 3 pieces 28 by 1 and ½ by ¾ inches (supports)
- 1 piece 4 by 4 by 1 inches } for stabilizers
- 4 pieces 3 by 1 by 1 inches }
- 2 card table hinges

Cost: approximately $3.00

Lapboard fits over arms of a wheelchair or ordinary chair and may be used for a work surface for all except heavy activities. It provides arm and elbow support and adequate working space lacking in over-bed tables. It is light weight, easily moved as necessary and may be handled by some patients. It saves space as it is smaller than over-bed tables and folds for easy storing when not in use. It can be placed at good working heights by adjustments with stabilizers, may be used with chairs of varying sizes, is easily constructed and inexpensive. There are no mechanical features to get out of order and can be constructed by patient or family for home use.

*Occupational Therapy Section, Veterans Administration Hospital, Houston, Texas

ABSTRACTS OF
ANNUAL REPORTS
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Hotel Morrison, Chicago, Illinois
October, 1959

EXECUTIVE DIRECTOR'S REPORT

The time comes each year to spread out before you the balance sheet of the Association, not in terms of dollars and cents, which the treasurer has done, but in terms of strengths and weaknesses of operation and accomplishment. Like all such sheets it can be made to look and sound like a rosy balance or there can be a harshness of imbalance. The year just concluded has had some of each. It is the intent of this report to refer to both.

The pattern employed in reporting to the membership at the annual meeting commissions me, as executive director, to report on behalf of all Association activities and committee chairmen.

I. *Association committees.* I consider it a privilege to summarize the performance of our committees. They are chaired and manned by full-time practicing therapists who give generously of their talent and efforts. Hundreds of therapists are involved and contributing. There is feeling that we have an over-abundance of committees. Perhaps so, but so has America! Until a better method is found by which to produce and provide wide-spread participation by a large cross-section of membership, we will have to stay with them. As an example of the structure of some committees, the membership of six of our standing committees is comprised of a representative from each of the state and regional associations. I do not recall the time when the national chairmen of these respective committees have ever announced a complete roster of membership. These committees are civil defense, history, legislation and civil service, special projects fund, special studies and recruitment.

Civil defense. This committee is the newest of these, and one of our methods of keeping abreast in this atomic and thermonuclear age. Closely related are the one-week mass casualty courses of informational instruction given by the Surgeon General's office in which occupational therapists have been invited to fill several of the limited places reserved. Three therapists attended the course at Walter Reed Army Medical Center earlier in the year, and one has just completed the current offering at Brooke Army Medical Center.

Special projects fund. This is the next newest committee, whose function is to raise funds from interested sources which will aid in the development of OT procedures, clinical and otherwise, thus enabling the undertaking of many needed projects being recommended by our membership. An ultimate goal of $200,000 has been established for the fund. Materials distributed by the committee to the membership this year include an *information sheet to be used by trust companies* and an *open letter to the membership and friends of the AOTA.* There is need for further definition and study on policy, investment, and schedule for effective disbursement of funds.

History of OT. This committee reports continued activity still confined to sorting and compiling 300 pounds of material from the national office archives. Requests for specific types of information indicate need for a catalog and index of what is extant. This is the objective toward which the committee is presently working.

Special studies. The 1959 survey of studies resulting from the questionnaire mailed country-wide indicated 210 studies in progress, and over 100 desirous of initiating something later. The compilation of the survey is on display in the educational exhibits. See it, and congratulations to the committee for utilizing this medium of communication. The current survey will be reproduced and made available. Criteria for pictures submitted to the AJOT picture page have been prepared.

Recruitment. Outstanding among accomplishments in the close working liaison with the department of public information were: conduct of the four regional recruitment workshops held in the East, South, Central and West Coast areas; establishment of permanent regional areas, with elected chairmen; showing of the TV spot film on CBS network, as well as local broadcasts (and it's still running); cooperation in the health scholarship program sponsored by the National Foundation which involves extensive local participation. Sixty-eight scholarships were awarded in occupational therapy from among the 300 applicants. This is an annual ongoing plan which must have our undiminished support toward remedying the desperate lack of students to fill our schools to capacity.

II. *Membership and general services.* The number of members served this year is slightly less than last year, but the number of O.T.R.'s is greater. The new inactive membership category for non-practicing O.T.R.'s which is going into effect now should improve this.

These membership services to you stem primarily from the national headquarters and the professional staff heading up its several divisions—public information, field consultancy, the *Journal*, education and general. In the statistical report you will find a resume of what the *Newsletter* has brought to you (it begins to look like the APA *Mail Pouch*, one of the most prolific on the market with its deluge of enclosures). These have kept you posted on new publications, graduate study opportunities, committee activities.

Placement and Referral, the *Yearbook*, and AOTA-recommended *Salary Schedule Guides* are additional membership services.

Publications. This is a continuing effort to increase the amount and improve the standard of our professional literature. The literature of a field is indicative of its maturity. The latest printing of our standard guide is the publications leaflet which lists 150 different manuals, texts, technical reprints, visual aids, career publications, plus approximately 200 materials available from the reference loan service. On hand in stock, ready to fill orders, are over 35,000 individual copies of all of these.

Off the press this year: *Changing Concepts and Practices in Psychiatric Occupational Therapy* (Allenberry Proceedings) which has sold 1,050 copies in the first six months. Also just off the press is the clever new recruitment piece, *Speaking of Occupational Therapy*, prepared by the director of public information. It should be subtitled, "How to Make a Speech and Like It."

Now on the press, for January release is *The Occupational Therapy Reference Manual for Physicians.*

American Journal of Occupational Therapy. What can more appropriately be termed a membership service than the official publication? Still in the black on the year's balance sheet, extraordinary for a publication with a 5,600 circulation, and made possible by a good editor, plus advertising which provides 35% of the revenue. Only ¼ of your membership dues goes there. Hence, to stay in the black we must support advertisers—echoes of the editor, who states, "Your prompt enthusiastic as-

sistance in returning the survey form has resulted in many new potential advertisers."

Field consultant in rehabilitation. This newest of our direct services to members is concerned primarily with the practicing occupational therapist in his contribution to patient care through improvement of existing OT services in his immediate working situation, related to administrative and/or technical clinical aspects of his program. We do know that it has doubled the number of centers visited and therapists contacted, and has provided a valuable additional direct liaison between therapists in the field and AOTA headquarters. It has also revealed some significant weaknesses in the field which should be of concern to us in professional practice. Among those frequently occurring are personnel shortages, setting of mutual treatment goals among staff supervisors, need for follow-up home care services, lack of administrative and medical support, the challenge of treatment program modifications in the shifting rehabilitation scene. An excellent interim evaluative report assessing the first half of this service has been prepared by the consultant and will be published.

Educational division. One of the major activities within the field of professioanl education includes further fulfillment of the plan for AMA/AOTA joint surveys of OT curriculums. Work during the year through the AMA advisory committee on OT education has resulted in the establishment of a full survey team comprising, in addition to the member of the AMA council on medical education and our AOTA director of education, another O.T.R., a physician basically oriented to OT education, and a representative of the official accrediting body for the region in which the institution is located. The first full team is poised for action and will be engaged in three surveys immediately following this conference.

Mention of the *registration committee* is made here as it is such an integral part of the Association's educational program, and is one of the hardest-working and consistently-at-work committees we have. This year they have proposed a revision of our policy of international reciprocity, due to the increasing number of applicants from countries with no formal OT curriculum as yet, and to provide better guidance of foreign therapists for study and work prior to writing the examination, which 54 foreign school graduates have done to date.

III. *Grants.* Grants continue to play an important role in our program and progress. We cannot do what we are doing professionally, with its far-reaching influence on members, without this type of support. You may be surprised to realize that grant personnel on the national office professional staff now outnumbers permanent staff members, six to four.

Here is what the $156,000 in grant monies, from United Cerebral Palsy, Office of Vocational Rehabilitation, and the National Foundation enabled us to do this year:

A. To award 126 undergraduate seholarships to students in 27 schools.

B. To continue expansion of the recruitment program, providing literature and working materials, visual aids, and essential improved communication through workshops and regional organization.

C. To put the now-famous curriculum study staff "on the road" where they have been for the past eight months, and will continue for another six months, gathering the vital field data. They are literally making history. Handle them with care! This is an ambitious effort to evaluate the occupational therapy curriculum through assessment of clinical practices and instructional procedures.

D. To continue the vital services of the field consultant in rehabilitation, whose visitations and consultations have markedly increased the field services contacts.

E. To provide limited stipends for O.T.R.'s attending the 1959 joint AHA/AOTA institute, and other short-term graduate study courses.

IV. *Significant projects, programs and activities which have transpired this year.*

A. Inter-agency activities with which we are in contact, or participating:

1. AMA joint committee to study paramedical areas in relation to medicine (includes eleven other related groups). An exploration of means for closer liaison among those participating in patient care, and for review of their positions on registration and licensure of members.

2. 1961 White House conference on the aging. The AOTA is registered as a participating agency. This is the first White House conference for the aging to be held and is comparable to the famous White House conferences on children.

3. International Health and Medical Research Act of 1959—about to become a law creating another National Institute of Health. This is not far removed from us. It can strengthen the work of voluntary agencies representing health professions, such as ours.

B. Stepping stones within AOTA:

1. Implementation of program to certify occupational therapy assistants, resulting from the hard work of the committee for recognition of the occupational therapy assistant. The education office handles the mechanics of operation. The story: 134 certified to date under the grandfather clause, from 17 states; 225 more being processed; one training program tentatively approved; curriculum guide being developed.

2. First joint House/Board meeting. Received recommendations of the special committee on relocation of the national office. Agreed of such value that a planning committee was appointed to arrange a second one at this conference.

3. Establishment of a roster of expert advisers in occupational therapy for the World Federation of Occupational Therapists, to refer to the World Health Organization when they require advice and assistance in rehabilitation.

4. Increased dues which went into effect the beginning of this year have made possible the first reimbursement to Association committees; an operating budget for the House of Delegates; expenses of all delegates to midyear House/Board meeting; financing of the relocation committee; increased travel for staff field work; increased grant to education division; additional personnel and office machine equipment for improved service efficiency.

And so, a panoramic view of the services and activities of your Association, a large part of which are dependent upon your interest and active participation. We hope that in the coming year we will find ourselves with sources of revenue and grants which will extend the $24 professional fees which each member pays, to approximately $53, as they have done this year.

I wish to acknowledge and commend the secretarial/clerical and professional staffs of the national headquarters for their splendid working relationship, and their part in making possible the extent and standard of accomplishment recorded in this report.

My sincerest thanks and appreciation to the members of the Association, the officers and the Board for their understanding and cooperation.

Let us go forward this year, not undiminished, but reinvigorated.

Respectfully submitted,
Marjorie Fish, O.T.R.
Executive Director.

1959 FACTS AND FIGURES

Here are some Association statistics for your interest and information prepared in conjunction with the annual report of the executive director. Space does not permit including the complete report which may be obtained from AOTA's national office.

	September 1959	September 1958
I. *MEMBERSHIP*		
Active	3,187	3,320
Sustaining	519	547
Associate	59	79
Associate Subscriber	83	95
Student	506	564
Honorary	17	17
	4,371	4,622
II. *REGISTRATION*		
Total Registrants	6,107	6,094
Practicing Non-Member OTR's	257	354
III. *ADDRESSOGRAPH RUNS*		
Preparation Membership/ Registration billing	22,182	22,583
IV. *CHANGES OF ADDRESS PROCESSED*	3,533	3,650
V. *OUTGOING MAIL*		
a) General Mail Room		
Letters	94,444	90,058
Bulk Packages	6,160	6,036
Public Information Division	206,846	142,170
Inquiries 7,299		
Literature 199,547		
	307,450	238,264

b) Newsletter

Total Mailings—52,800

Enclosures — 27

Summary of what these brought you:

New Publications—fact sheet; publications available leaflet and revision list; announcement flyer on Allenberry Proceeding, kinesiology text, *Medical Writing* (Wisconsin OT Ass'n); *Speaking of OT* booklet; order form for publications.

Committees—special studies survey questionnaire; special projects fund statement; Wisconsin OT Association cook book request; relocation of national office; joint House/Board planning committee.

Courses of study—announcements from Western Michigan University; University of Pennsylvania; University of Colorado.

Civil Service—announcement of qualifying examination for N. Y. State; U. S. Dept. of Health, Education and Welfare.

1959 annual conference—preliminary program and other materials

VI. *PLACEMENT SERVICES*	
Requests from U. S. therapists (including applications)	222
Requests from U. S. therapists for foreign placement information	26
Requests from foreign therapists	40
"Positions Available" lists mailed (published quarterly)	701
Institutions listed	375

VII. *AJOT*	1959	1958
Total Circulation	5579	5800
Members	4501	
Non-Members	975	
Complimentary	103	

Foreign Circulation:

Argentina	Greece	Poland
Australia	India	Portugal
Austria	Indonesia	Russia
Belgium	Iran	Scotland
Brazil	Israel	South Africa
Canada	Italy	Spain
Chile	Japan	Sweden
Costa Rica	Mexico	Switzerland
Cuba	The Netherlands	Taiwan
Denmark	New Zealand	Thailand
England	Norway	Turkey
Finland	Pakistan	Uruguay
France	Panama	Venezuela
Germany	The Philippines	Yugoslavia

XI. *AOTA COMMITTEES*

Standing Committees	*Chairmen*
Civil defense	Martha Schnebly, O.T.R.
Clinical procedures	Capt. Lottie Blanton, O.T.R.
History	Marianne Catterton, O.T.R.
International	Marie Louise Franciscus, O.T.R.
Legislative and civil service	Virginia Caskey, O.T.R.
Nominating	Mary Van Gorden, O.T.R.
Permanent conference	Winifred Kahmann, O.T.R.
Subcommittee on conference appraisal	Robert Belyea, O.T.R.
Recognition of OT assistants	Marion Crampton, O.T.R.
Recognitions	Florence Stattel, O.T.R.
Recruitment and publicity	Mrs. Frances Shuff, O.T.R.
Registration	Virginia Kilburn, O.T.R.
Special projects fund	Elizabeth Collins, O.T.R.
Special studies	Julie Shaperman, O.T.R.

Special Committees	
Constitution revision	Ruth Zieke, O.T.R.
AOTA structure and function (development advisory)	Wilma West, O.T.R.
OT Reference Manual for Physicians	Marguerite Abbott, O.T.R.
Revision of *AOTA Administrative Practices and Personnel Policies*	Elizabeth Jameson, O.T.R.
Revision of *Manual on Department Organization and Administration*	Cornelia Watson Beck, O.T.R.
Subcommittee on national office personnel policies	Naida Ackley, O.T.R.
Joint House/Board planning	Marjorie Holtom, O.T.R.

House of Delegates Special Committees	
Committee expense funds	Mrs. Arvilla Merrill, O.T.R.
Group insurance	Dorothy Park Kataoka, O.T.R.
House organs revision	Mary Van Gorden, O.T.R.
Malpractice insurance	Joy Collins, O.T.R.
Treatment fees	Clara Dubbs, O.T.R.

FINANCIAL STATEMENT

Statement of Income, Expense and Fund Balances

for the Fiscal Year Ended June 30, 1959

GENERAL FUND	Budget For Year	Actual For Year	Actual Over or (Under)
INCOME:			
Registration fees	$ 67,000.00	$ 66,567.00	$ (433.00)
Members' dues	33,500.00	36,739.97	3,239.97
A.J.O.T. subscriptions—members	19,000.00	13,119.50) 5,817.42)	
A.J.O.T. subscriptions—other			
A.J.O.T. advertising	11,000.00	11,852.53	852.53
Sales of literature, etc.	4,000.00	4,204.61	204.61
Yearbook advertising—net of discounts and commissions	1,700.00	1,558.24	(141.76)
Volunteer course	100.00	83.75	(16.25)
Annual conference	17,500.00	21,611.20	4,111.20
Interest on bonds and bank balances	1,200.00	2,397.08	1,197.08
Donations	100.00	255.00	155.00
Administration fees		5,048.86	5,048.86
TOTAL INCOME	$155,100.00	$169,255.16	$14,155.16
EXPENSE:			
Salaries—professional	13,460.00	13,900.40	440.40
Salaries—secretarial	26,379.00	25,898.49	(480.02)
Salaries—temporary help	2,200.00	3,680.73	1,480.73
Travel	3,000.00	6,844.48	3,844.48
Cooperation with other agencies	1,000.00	967.60	(32.40)
Recruitment and publicity	500.00	.....	(500.00)
Exhibits	500.00	148.45	(351.55)
Office repairs	100.00	45.90	(54.10)
Postage and express	3,500.00	2,991.61	(508.39)
Books and subscriptions	250.00	103.76	(146.24)
Rent and light	4,473.00	6,504.84	2,031.84
Telephone and telegraph	1,000.00	851.71	(148.29)
Legal and auditing	1,000.00	1,001.00	1.00
Gratuities	175.00	179.25	4.25
A.J.O.T.—costs, expenses, etc. (Schedule B-1)	30,000.00	30,597.41	597.41
Yearbook—postage and mailing	2,500.00	1,727.42	(772.58)
Yearbook—printing	8,500.00	8,095.99	(404.01)
Annual conference	14,500.00	19,557.25	5,057.25
Newsletter	2,200.00	2,587.71	387.71
Purchases of literature, etc.	4,000.00	2,574.10	(1,425.90)
Office supplies	3,250.00	4,068.53	818.53
Office expenses	2,250.00	1,560.65	(689.35)
Printing	1,800.00	1,982.30	182.30
Taxes and insurance	1,200.00	1,773.75	573.75
Miscellaneous	75.00	55.35	(19.65)
Consultancy	500.00	345.00	(155.00)
House of delegates — expenses	2,000.00	575.76	(1,424.24)
Executive Committee/Board—expenses	1,500.00	1,053.12	(446.88)
Committee expenses	1,500.00	1,412.89	(87.11)
Grant to Educational Fund	20,000.00	20,000.00	.....
Depreciation	1,175.00	1,225.18	50.18
TOTAL EXPENSE	$154,487.00	$162,311.12	$ 7,824.12
EXCESS OF INCOME OVER EXPENSE	$ 613.00	$ 6,944.04	
Fund Balance—July 1, 1958		49,639.48	
FUND BALANCE—June 30, 1959		$ 56,583.52	

EDUCATIONAL FUND

INCOME:			
Grant from General Fund	$ 20,000.00	$ 20,000.00	
Registration examination fees	7,500.00	8,069.00	$ 569.00
Initial registration fees	4,000.00	4,731.00	731.00
Sale of educational materials—including royalties $387.28	1,000.00	1,554.98	554.98
Conference—Institute	4,000.00	.....	(4,000.00)
Special services—fees	1,200.00	1,506.00	306.00
Interest on bank balance	50.00	102.39	52.39
TOTAL INCOME	$ 37,750.00	$ 35,963.37	($1,786.63
EXPENSE:			
Salaries—professional	11,450.00	11,416.74	(33.26)
Salaries—secretarial	5,265.00	5,058.34	(206.66)
Travel	1,500.00	1,787.83	287.83
Office repairs	50.00	16.50	(33.50)
Postage and express	500.00	370.71	(129.29)
Rent and light	3,515.00	3,579.60	64.60
Telephone and telegraph	400.00	558.89	158.89
Legal and auditing	289.00	539.00	250.00
Conference—Institute	2,000.00	.....	(2,000.00)
Purchases of educational materials	500.00	831.73	331.73
Office supplies and expenses	750.00	753.78	3.78
Printing	500.00	199.40	(300.60)
Taxes and insurance	300.00	627.09	327.09
Miscellaneous	50.00	.....	(50.00)
Consultancy	6,500.00	4,782.00	(1,718.00)
Computations	500.00	433.00	(67.00)
Special services	1,200.00	1,512.05	312.05
Registration examination expense	1,500.00	2,320.76	820.76
Registration examination items	300.00	11.00	(289.00)
Registration committee expense	600.00	680.93	80.93
TOTAL EXPENSE	$ 37,669.00	$ 35,479.35	($2,189.65)
EXCESS OF INCOME OVER EXPENSE	$ 81.00	$ 484.02	

AOTA RESERVE FUNDS

Cash in Banks and On Hand:		
Chase Manhattan Bank	$20,199.92	.....
Savings Banks	18,511.73	.....
Office Cash Funds	449.25	$39,160.90
Investments—U. S. Government Bonds:		
General Fund	$ 5,600.00	.....
Endowment Fund	18,400.00	$24,000.00
		$63,160.90
Liabilities and Reserves:		
Accounts Payable	$ 4,223.86	.....
Reserve for Loans to post graduate students	1,243.87	.....
Reserve for Research Projects	132.00	$ 5,599.73

Respectfully submitted,
Wilma West, O.T.R.
Treasurer

EDITORIAL REPORT

Student members do not have an opportunity to join AOTA until after school starts in the fall and new registrants, successfully completing the June registration exam, do not join until August. Because of the detail of processing, it is even later before the AJOT office receives the list of new members.

Up to now it has been AOTA policy to accept new members for the current year up to September 1 and supply them with back issues of the Journal. As an inducement to join early and to make certain they receive an advantage in joining, would it be possible to offer all new members joining after July 1 a paid-in-full membership for the following year. That offers them their entitled privileges for the remainder of the year but does not entitle them to back issues of the Journal. This arrangement would contact them at the propitious moment, and is an inducement to join but does not penalize them with two dues in the short space of a few months.

As editor, I am making this recommendation because (1) it is difficult to anticipate enough February issues and (2) this action would save the cost of mailing back issues. Extra copies are run in an attempt to estimate new and late subscriptions which works satisfactorily until the end of the summer, but by then requests for back copies have usually exceeded the February run.

Although this suggestion would enable the Journal office to operate more efficiently, it would also offer an advantage to new members by offering an early membership in AOTA and a membership is easier to keep than it is to instigate without an inducement.

Beginning with the next volume of AJOT (January-February, 1960) a new section of display ads entitled "Where to Buy" will be initiated. The section will be three columns wide so the ads will only be two inches wide instead of three. The center column will carry news about products for therapists found in the advertising pages. These smaller ads will offer the small supplier an opportunity to also advertise.

The returns are being received from the purchasing questionnaire sent to OT departments early in September. The enthusiastic cooperation of OT department heads is making this a valuable survey.

The Congress of the World Federation of Occupational Therapists will be held in Philadelphia in 1962 and their meetings will take the place of our usual conference. The proceedings of this meeting will be published by the World Federation. Therefore the Board of Management voted to suspend the conference issue for 1962.

Every year some requests are made for copies of speeches immediately following the conference. The Board voted that no papers are to be released prior to publication in the conference issue.

Respectfully submitted,
Lucie Spence Murphy, *Editor.*

DIRECTOR OF EDUCATION'S REPORT

The following summary covers major activities of the education division with the exception of those contained in the annual report of the registration committee.

Education division staff. The professional staff consists of two full-time O.T.R.'s, Miss Mildred Schwagmeyer and Miss Virginia T. Kilburn. Dr. Hyman Brandt is employed on a part-time basis as educational research consultant with main responsibilities relating to the registration examination.

Curriculum study project. The education division staff is continuing to meet at intervals with the project staff and to study the data being sent back from the field by the project personnel.

AMA/AOTA joint surveys of occupational therapy curriculums. The AMA advisory committee on occupational therapy education, the council on medical education and hospitals (CME&H) of the AMA, and the council on education of the AOTA have approved the inclusion of two to three more persons on the survey team. In addition to the assistant secretary of the CME&H and the director of education of the AOTA, the team is to include one registered occupational therapist and one physician basically oriented to occupational therapy education. At the request and expense of the institution being surveyed, a representative of the official regional accrediting body will be asked to join the survey team. The AMA-CME&H has agreed to pay the expenses of the two physicians, and AOTA is being asked to do the same for the two occupational therapists.

It is hoped that eight to ten surveys may be done each year. In November, 1959, the team will survey the occupational therapy curriculums at the College of Puget Sound, University of Washington, and College of Medical Evangelists. Joint surveys have been conducted at the following universities: Illinois, Indiana and North Dakota.

Following a progress report received from the Boston School of Occupational Therapy, notification was received that the school is in the process of being merged with Tufts University and that a subsequent progress report would await developments.

New and prospective curriculums in occupational therapy. The following institutions admitted occupational therapy students to junior status this fall: College of Medical Evangelists, University of Florida and University of Washington. In November, 1958, the director of education visited, as their request, with faculty of the University of Michigan to discuss the feasibility of starting an occupational therapy curriculum. It is our understanding that the University of California Medical Center and Sargent College of Boston University are continuing plans to establish curriculums.

Certification of occupational therapy assistants. Both professional and secretarial staff have devoted increased time to this program since the midyear meeting. Statistics will be found in the report of the chairman of the committee. The assistant director of education has continued to work closely with the committee. Most of the forms have been revised and additional form letters have been composed. The assitant director has attended the three committee meetings this year. The problem of handling these mechanics within the present staff limits of the education division will become more and more serious as the certification program expands.

Location of certified occupational therapy assistants are: Colorado, 2; Connecticut, 3; Hawaii, 1; Indiana, 5; Iowa, 1; Maryland, 3; Massachusetts, 27; New Jersey, 2; New York, 54; North Carolina, 5; Ohio, 1; Oklahoma, 4; Oregon, 4; Pennsylvania, 2; Vermont, 2; Virginia, 11; Wisconsin, 7.

Enrollment data. During the spring semester, 1959, there were 1851 degree or advanced standing students (including 29 foreign and 86 male, and 29 master's degree candidates enrolled in 30 institutions.

Report of performance in student affiliation (RPSA). The revised form which went into effect September 1, 1958, is continuing to pose many problems. For further details re the RPSA see the report of the registration committee.

There continues to be delay in announcing the results of the registration examination owing to late receipt of

RPSA's for students completing clinical training the month following the examination. Student affiliation directors are asked to mail these reports to the curriculum directors soon after the student signs them at the final conference.

Owing to the mechanics of tabulating the RPSA scores for the total registration score, *it is imperative* that separate RPSA's be submitted by clinical directors for affiliations in GM/S and neurology/orthopedics. A number of forms are still being received indicating a single rating for 4-8 weeks in GM/S and 8-12 weeks in neurology/orthopedics. The RPSA forms must be signed by *both* the student and the rater or person who goes over the form with the student at his final conference.

Area analysis and relative school standing. Costs for analyses of the performance of registration examinees have risen sharply. In September, 1957, the cost was $2.25 per student; in September, 1958, $3.54. Figures for September, 1959, are not yet available. The increase is mainly attributable to the decreased number of students taking the examination as well as to increased costs of labor and supplies. Secretarial time and that of the director of education are not included in the cost. Each school is billed according to the number of its students taking the examination.

Scholarships. United Cerebral Palsy Research and Educational Foundation, Inc. During the academic year 1958-1959, 46 undergraduate students received scholarships from the $10,000 UCP fund. These students were enrolled in 28 colleges or universities and came from 23 states.

A continuing grant of $10,000 for the academic year 1959-1960 has been approved by UCP and the administration procedures are similar to those used last year. Each participating institution is receiving 56.9% of one year's tuition. The curriculum directors are asked to notify the education division as to the total number of students who submit applications for screening by the college or university.

Office of Vocational Rehabilitation, Department of Health, Education and Welfare.

The $35,000 under this special traineeship grant were distributed as follows:

Academic Level	*No. of Students*	*Total Awarded*
Junior	33	$ 8,200.00
Senior	13	5,200.00
Advanced Standing	15	7,800.00
Clinical Year	19	6,600.00
Graduate (M.A. degree)	3	7,200.00
Totals	83	$35,000.00

The 83 students were enrolled in 27 colleges or universities.

A number of OTR's were enabled to attend the AHA/AOTA Institute in April through an OVR grant to the AOTA.

National Society Daughters of American Revolution. The grant of $2,500 was awarded to five recipients in amounts of $500 each. Forty-three applications were screened by the sub-committee on scholarships. Four were received too late to be considered.

National Association of American Business Clubs. This association made direct grants totaling $3,300 to 12 occupational therapy students during the academic year 1958-59. They have also awarded $3,175.00 to nine students this fall.

National Society Crippled Children & Adults, Inc. The society gave scholarships to five occupational therapy students in 1958-59 and has recently given awards to four students for this year.

On behalf of the Board of Management and the AOTA membership, sincere appreciation has been expressed to the above benefactors for their very substantial help in assisting worthy students.

Institutes and Workshops. The 1959 AHA/AOTA Institute was held in Waco, Texas, April 28-May 1. Forty-five persons from 14 states were registered. It is anticipated that the 1960 institute will be held in Chicago in conjunction with the Tri-State meeting.

June 8-10, 1959, the National Foundation held an informal conference in Palo Alto, California, to discuss graduate programs in occupational and physical therapy. A committee, composed of those occupational therapists and physical therapists present from California, was asked to further explore our individual and mutual professional needs in graduate education.

I should like to express my sincere thanks to the Board of Management, the chairmen and members of the education committees, the executive director, and the staff of the education division for their loyal support and guidance.

Respectfully submitted,
Virginia T. Kilburn, O.T.R.
Director of Education

FIELD CONSULTANT'S REPORT (Rehabilitation)

The consultant has the responsibility of counseling with anyone who requests assistance on matters related to the organization and/or technical clinical aspects of an occupational therapy program. Counseling may be done through correspondence or field visits. Selected requests may of necessity be referred to other agencies or to committees within the Association, since these committees are composed of members whose proficiency within their specialties provides the best source of information.

The consultant has found that field visits have provided the therapists an opportunity to think out loud, to talk over some of the problems which have been worrying them and to help them to see these problems in the proper perspective. With a little guidance they have been able to speculate on the causes of their difficulties and to work toward a solution. This, in the opinion of the consultant, is of primary importance. She does not attempt to solve the problems for the therapists, but stimulates them to direct their efforts so that a solution might well result.

Another advantage of having such a service within the Association is that it provides an additional liaison between the practicing therapist and the national headquarters. Frequently, therapists will remark that before the time of the visit from the consultant, the national office seemed quite remote and that there was some hesitancy in turning to the professional staff for advice and assistance. Personal contact with a representative from the office helps to dispel these feelings.

The field consultant has opportunity to observe areas of need or problems which are just beginning to give some cause for concern and reports back to the appropriate persons so as to focus attention on these matters and avoid having them reach undue proportions.

The impact of these contacts and the influence they have in furthering the development and refinement of occupational therapy programs as a vital part of the over-all rehabilitation plan is of far-reaching significance.

The services of the consultant are in demand over a wide geographical spread since there are facilities in all of the 50 states as well as Puerto Rico. To date, 129 centers in 60 cities and 25 states have been visited. There is a broad professional distribution of services as

well, since the physical disabilities area covers such a wide variety of types of centers and the treatment of numerous disease entities.

I. Preparation of Field Schedules. Assistance may be requested on a specific problem or problems of immediate urgency. In such cases the consultant attempts to schedule in order to be of help during the emergency. The majority of requests are on general, continuing, less urgent matters so that the consultant notifies the president of the occupational therapy association in the state involved of these requests. The president, in turn, works through the membership and checks with all therapists within the locality to see if they desire time with the consultant. The association president then notifies the national office as to how much time should be allocated, and the field schedule is made up on the basis of such requests.

Through the *Newsletter*, suggestions have been made as to how the therapist could most effectively prepare for consultancy services prior to visitation. A copy of this Newsletter is sent to the president of the association when plans are being formulated and the membership is reminded of these expectations in order that the consultant can prepare herself for the most effective assistance.

II. Problems Often Encountered.

Personnel shortages. Occupational therapy, like all other disciplines in the rehabilitation field, is woefully short of personnel. It is not likely within the foreseeable future that the profession will be able to train sufficient people to fill all of the existing vacancies. A common cause for many of the problems brought to the attention of the consultant is this need for additional personnel. In some situations, something can be done since administrators may take the advice of the consultant to improve salary levels and benefits to the workers so that qualified people can be attracted to what has been an uninviting position.

The recruitment of aides and assistants as well as volunteers is stressed by the consultant. The responsibility that goes along with the use of these volunteers or semi-skilled people is pointed out. Careful screening and thorough indoctrination are essential to any such program. In the situations where there is a director of volunteers, much of the responsibility for screening falls to that person, but it still remains the duty of the therapist to orient and instruct those assigned to his department. Volunteers who are made to feel that they are contributing a valuable service and have adequate guidance are usually very dependable. Carefully selected aides can develop to the point at which they are able to play a vital role within an understaffed occupational therapy department but the development of these people depends upon the ability of the therapists to direct their activities. It is pointed out that AOTA has an approved training course for occupational therapy assistance in the field of psychiatry and that work is being done on setting up a similar program for training in other disability areas. The time and effort involved in such training programs is well invested since the certified occupational therapy assistant will be able to relieve the registered therapist of much of the routine work involved in a daily treatment program.

Therapists working in pediatrics or tuberculosis programs frequently report demands put upon them that are beyond what they can adequately handle. The huge numbers of patients who are assigned to work in occupational therapy eliminate the opportunity for the therapists to know enough about the condition of each patient to treat him as he should be treated. The same situation is found to exist in other disability areas as well. In such cases the consultant helps the therapists reorganize their programs so that the emphasis is upon the part that is more therapeutically beneficial to the greatest number of patients and certain areas of responsibility which could be assumed by someone else are de-emphasized.

Since therapy is based on individualizing the treatment plan so as to fit the activities to the needs of the patients, the therapists are justified in their concern over the situation. The consultant urges each therapist to do everything in his power to keep his program geared to a level whereby sufficient time is available to understand the problems involved in the treatment of patients so that his services will not deteriorate into those of a storekeeper handing out supplies.

Setting of goals. The lack of common goals for the rehabilitation efforts in the centers has been found to be unfavorably widespread. In several instances, it was the privilege of the consultant to talk with the entire staff of a treatment unit. At such times, the most conspicuous shortcoming admitted by the groups was that they seldom found time to sit together to discuss their patients and to find out what they all had as common treatment objectives. True, written communication was sometimes used, but the consultant advised that nothing was a satisfactory substitute for the interchange of ideas in a staff conference.

Need for follow-up services. The consultant has found a growing need for follow-up services in the home and is suggesting that many centers set up some program of extended care. Since service within the centers costs more than most families or supporting agencies can afford on a long-term basis, the patients are often discharged before it is advisable. Rather than have all of the rehabilitation efforts invested count for naught, a system of home follow-up has been suggested which not only includes periodic visits to the home of the individual after his discharge to re-evaluate the condition of the patient and check on his activities program, but often allows for a visit to the home prior to the time of discharge in order to offer suggestions to the family on changes that can be made to improve the situation and permit the patient to function at his maximum. Actually seeing the home situation or talking with a social worker who knows the details of the situation enables the therapist to work out a much more realistic home program.

Poor administrative and medical support. Frequently therapists state that the hospital administrator has little or no understanding of the value of occupational therapy. In such cases, the consultant attempts to have each therapist analyze and define his own role to make clear the need for basic understanding on his part before endeavoring to indoctrinate others. If the therapist is prepared to present specifics when in consultation, this gives the administrator an opportunity to gain more insight and build up appreciation for the services offered through occupational therapy.

Doctors often frankly admit that they are poorly prepared to make full use of occupational therapy since they are not aware of the variety of ways in which occupational therapy can benefit their patients. The consultant may be able to point out some treatment objectives during the usual brief contact with the medical staff but it is impossible to do a thorough job. For that reason the responsibility falls to the occupational therapist to continue with this educational program and take every opportunity to help the doctor gain sufficient knowledge and understanding so that he feels comfortable in referring patients to the service. The consultant advises therapists to accompany the physician on ward rounds and contribute pertinent information when pos-

sible. Carefully worded progress notes aid in the doctors' knowledge of what is being accomplished through occupational therapy so they serve a double purpose. Therapists are urged to use terminology which is familiar to the physician and to avoid the use of occupational therapy jargon.

Specific program needs. There have been numerous requests for assistance in the pre-vocational area and in geriatric programming. The consultant encourages the centers interested in developing pre-vocational programs to investigate the real need for such a service, since there should not be unnecessary duplication of services within a community. If it is clear that pre-vocational exploration should be developed within the center, then suggestions are made as to methods of procedure. It is suggested that the staff visit some of the centers which have had experience in setting up such programs, and information as to available training in this field is supplied. Stress is put upon the importance of a good basic program which will supply specific information as to the ability of the patient to care for his personal needs, the degree of independence in use of public transportation, and findings pertaining to manual dexterity and coordination. If job samples are to be used, the staff is urged to investigate employment opportunities within the community before selecting the particular samples that will be included so that realistic findings will result.

The consultant advises that geriatric programs, in general, be as practical as possible since their prime purpose is to encourage the patients to be self-reliant and useful. Kitchen and gardening activities are suggested if not already available and major stress is put upon self-care. Recreational activities are also a phase of any geriatric program and should be included in occupational therapy unless planned by some other group within the unit.

Various other problems have been presented to the consultant applicable to the specific needs of the programs involved. Included have been questions pertaining to special equipment of various kinds, budgets, fees, planning for improvement of existing physical facilities and assistance with certain treatment methods and techniques. These are dealt with individually and it would be difficult to generalize on them since so many of them are of a very specific nature.

III. Interprofessional Activities. The field consultant is called upon to participate in inter-agency affairs. Included have been requests to serve on committees, to attend conferences or institutes, to speak at various meetings and to serve in an advisory capacity on special projects. These contacts have aided in establishing a closer bond between agencies and information obtained has been mutually beneficial.

IV. Future Plans. The consultant has expressed the need for a committee to function in an advisory capacity to the field consultancy service. This committee has been appointed and its members will be representative of a variety of types of programs. This will make it possible to have guidance on possible solutions to some of the problems encountered in areas in which the consultant feels that broad interpretation by the committee members and combined thinking will be advantageous. This committee could also assist in pointing out geographical areas where there is an evidence of need since its members will be in a better position to sense some of these needs and interpret them. In fact, this group can serve as a sounding board for the membership and help the consultant to formulate field schedules which will be most beneficial to the greatest number of therapists.

Other assignments for this committee will be: (1) periodic evaluation of the program, (2) set up policies and guide lines for field visits, (3) suggest improved methods of recording and reporting, (4) give consideration to specific problems referred by the consultant such as those related to self-employed therapists, (5) stimulate interest in the formulation of more specific tests and measurements for occupational therapy.

The consultant will continue to work closely with allied health agencies, participate in conferences and institutes, and serve on committees when requested insofar as she is able without curtailing her field schedule unduly.

It has been the policy of the consultant to be in the field about two-thirds of the time. In the future, this will have to be reduced since it has become evident that essential records and reports cannot be handled unless the time in the office is increased.

Through all of these various activities the consultant has one goal uppermost in mind: to aid in improving the services rendered by occupational therapists in the rehabilitation programs throughout the country.

V. Summary. There is no doubt that this consultation program has been of value to the individual members contacted and to the association as a whole. Reports from the field state that therapists have often been able to incorporate ideas worked out with the consultant in an effective way and have been able to accomplish this in a reasonably short time. Others report that program revisions which are more extensive have not been adopted immediately but that they have been taken under consideration and planning is being done with the hope that full realization will eventually be possible. A gradual but thorough approach to these problems is considered desirable since they often involve several departments and call for the coordinate effort of many individuals. As long as there is an effort to improve patient care in individual occupational therapy departments, we can rest assured that the profession as a whole will profit, since the accomplishments of the individual members reflect and influence the status of the profession.

It is anticipated that the consultancy service will be able to refine its policies and operational procedures in order to improve the services it performs, and that with continued interest in, and use of the service by occupational therapists and outside agencies commensurate improvement in patient care will ultimately result.

Respectfully submitted,
Irene Hollis, O.T.R.
Field Consultant in Rehabilitation

WORLD FEDERATION OF OCCUPATIONAL THERAPISTS

This report will serve to review the major activities of the World Federation of Occupational Therapists during the past year and report accomplishments. In February, 1959, President Spackman informed all member countries in a WFOT Newsletter that: "The World Federation of Occupational Therapists was admitted into official relations with the World Health Organization . . ." In May, we were represented at the World Health Organization meetings in Geneva by Mrs. Glyn Owens, M.B.E., T.M.A.O.T., assistant honorary secretary-treasurer WFOT (England) and Miss Dulcie Goode, T.M.A.O.T., first vice-president WFOT (Australia).

To meet, in part, the responsibilities inherent in this recognition by the World Health Organization and to assist in the development of occupational therapy around the world, the World Federation is in the process of developing informational materials and channels for the exchange of information and advisory services. Toward that end the following three specific programs have been activated or further developed during the year.

Publications. "Two of our publications, *The Establishment of a Program for the Education of Occupa-*

tional Therapists and the *Organization of an Occupational Therapy Department* were translated into Spanish and are now available for sale at $.50 each. An important publication that is just off the press is *Occupational Therapy as a Link in Rehabilitation*, the proceedings of the second world congress in Copenhagen in 1958. This includes resumes of the excellent papers presented at the congress and will be a valuable resource for all of us. As determined by the WFOT council, it will be distributed free of charge to all who were active members of WFOT in August, 1958, and may be purchased by others for $2.50 from the AOTA.

Visual aids. The World Federation has undertaken the task of establishing a representative library of treatment slides and photographs for use at international conferences of allied groups. Each member country has been invited to submit contributions, and this collection is being made in the United States by your AOTA international committee.

Consultant services. A third activity undertaken is the establishment of a roster of therapists who can serve as "Expert Advisors" in countries requesting assistance. This was reported to you in your AOTA *Newsletter*, June, 1959, including the qualifications for an expert advisor as recommended by WFOT.

WFOT was officially represented at the third international congress of the World Confederation of Physical Therapy in Paris, August, 1959, by Miss Dorothy Byram Bramwell, M.B.E., M.S.A.O.T., director of occupational therapy, Astley Ainslie Hospital, Edinburgh, Scotland.

The next scheduled meetings of WFOT are:

Council: Sydney, Australia, September, 1960.

Third World Congress: Philadelphia, U.S.A., October, 1962.

Plans are beginning to formulate for the third world congress when the AOTA will play host to the World Federation. Further details of these are included in another report.

FOR BOARD ACTION

1. The next meeting of the WFOT Council is scheduled to convene in Sydney, Australia, September 12-18, 1960. The AOTA will be represented at this meeting by the 1st and 2nd alternate delegates, Misses Willard and Fish, as the delegate, Miss Franciscus, is unable to attend. We are asked to submit by January, 1960, any items we would like included on the agenda under "Other Business." Your delegates would like to suggest that consideration be given to the establishment of a like policy in all countries for the determination of the membership-year of individual members who join the Federation at odd times during the year other than at the regular billing date of the Federation. Any items that the Board would like to have included on the agenda will be appreciated

2. We have been requested to submit names of outstanding leaders in medicine, rehabilitation, etc., who could be elected to serve as advisory fellows. At the present time, five such fellows have been appointed, of which three are from the United States: Dr. Howard Rusk, Dr. Henry Kessler, Miss Mary Switzer. In view of this and if it meets with your approval, your delegates would suggest that we decline to make further nominations at this time.

Respectfully submitted,
Marie L. Franciscus, *Delegate*
Helen S. Willard, *1st Alternate*
Marjorie Fish, *2nd Alternate*

NOMINATING COMMITTEE

Members of the 1959 nominating committee enjoyed the opportunity of working on this vital committee. It was reassuring to learn that the American Occupational Therapy Association places emphasis on a democratic method of selecting candidates for office.

Although the committee felt that the standing operating procedure for the committee is basically efficient, it was agreed by all members that the method of operation is not entirely in keeping with the needs of such a dynamic and growing organization. Members of the committee were urged to send comments and suggestions to the chairman following completion of the assigned work. A condensation of the comments made is as follows:

Chief Complaints:

1. The lists of suggestions received were heavily loaded with therapists from the educational field.
2. The "same old names" keep coming up each year.
3. Many names were submitted without biographical information.
4. Many well-qualified people will be eliminated because they are not "known."
5. "My overall feeling was one of dissatisfaction, an uncomfortable feeling that this system could result in many good candidates being overlooked."
6. "The final selection falls to too few, considering the number in the field at the present time."
7. "More emphasis to the membership and to the delegates on the importance of full participation and cooperation is apparently needed prior to the time suggestions are submitted. Judging from this area, some of the delegates do not realize their responsibility in this matter. For example, one association submitted a total of two names, another submitted a full list but included no additional information. Follow-up letters on these sketchy lists were not answered, and even a personal conversation with one of the delegates failed to produce any better results."
8. More clarification is needed regarding qualifications for the various offices.
9. As the present system stands, a member can emphasize his candidate by submitting the name to more than one nominating committee member.

Suggestions:

1. Qualifications for all offices be set up.
2. Divide the country into six or seven areas, with a nominating committee member in each area. States would submit names only to their own area committee member.
3. Send letter requesting possible candidate to each member of the association, rather than just through the delegates. A form would be included with the letter and would be used to submit a name. It would include all necessary information about the potential candidate. If a member wanted to submit more than one name, he would copy the form, using the same basic layout for each name submitted. These forms would be sent directly to the area committee member, not the delegate. The area committee member would sort out the names and could always write to delegates for additional information or comments on the possible candidates. He would then formulate a double slate of candidates, getting these people's consent to serve on a "consent to serve form" . . . and would then mail his proposed slate to every other committee member. This procedure would continue until a slate which is acceptable to all committee members is formulated.
4. Ideally, it would probably be best if the nominating committee could meet together before compiling the

final slate. We understand that this happens in the APTA, but may not yet be realistic for us.

5. It might be wise to have the committee chairman serve more than one year.

6. It would be helpful to have a list of people who have served on various national committees and as officers during the past five years.

7. It would be helpful to have a list of names which were submitted in the previous year, with notes as to which names the committee seriously considered but did not include in the final selection.

8. Members of the association might benefit from more, and repeated, information regarding nominations and elections, including the importance of the matter, things to consider when submitting names, etc. The delegates should be more helpful here.

9. It might help to set the committee's schedule ahead a little, especially to allow for more time (and better time) for the final stages of the work. As it now stands, it is very easy to be inconvenienced by summer vacations.

Our committee hopes that these suggestions may be of some assistance. We found the committee's SOP to be very well organized and efficient, but we all admit that we finished our work feeling a little uneasy about the whole operation.

Eileen O'Hearn, O.T.R.
Margery Peple, O.T.R.
Irene Robertson, O.T.R
Jerry Johnson, O.T.R.
Jeannine Dennis, O.T.R.
Luba Faris, O.T.R.
Mary Van Gorden, O.T.R., *Chairman*

INTERNATIONAL COMMITTEE

The committee met on October 17, 1959, with all members present. The committee reviewed its purposes, projects and accomplishments to date.

Consideration was given to the mechanics of establishing a roster of "expert-advisors" (see announcement in *Newsletter* June, 1959). This roster would be used by WFOT, along with similar rosters from all member countries, as requests come for consultation services for under-developed countries. Application information needed was determined; a method of foreign language screening is to be worked out; the application material will be compiled by the AOTA office; final applications will be reviewed by a panel of the committee. Further clarification of the "expert-advisor" program will accompany the January *Newsletter*. A collection of treatment pictures and 35 mm colored slides is being made to contribute to a WFOT exhibit for use at international meetings of allied groups.

Information is being collected concerning policies, channels and mechanics for the professional activity of other organizations in this country. This concerns the policies of immigration authorities of states and of universities, program members available, and consideration of central registration.

It was decided to try to stimulate interest in international activities and WFOT membership by means of an "internationally speaking" column in AJOT in February and by including a WFOT membership application with a *Newsletter* mailing.

Respectfully submitted,
Marie Louise Franciscus, O.T.R.
Chairman

RECOGNITION OF OCCUPATIONAL THERAPY ASSISTANTS COMMITTEE

The committee has certified 134 applicants and rejected 10. In addition, 225 applications are being processed. The geographic distribution of those certified is as follows: Colorado, 2; Connecticut, 3; Hawaii, 1; Indiana, 5; Iowa, 1; Maryland, 3; Massachusetts, 27; New Jersey, 2; New York, 54; North Carolina, 5; Ohio, 1; Oklahoma, 4; Oregon, 4; Pennsylvania, 2; Vermont, 2; Virginia, 11; Wisconsin, 7.

Processing applications is often a lengthy procedure. Sometimes applicants do not give sufficient information on the application form and must be contacted for additional data. Frequently those who are asked to write references delay in submitting them. At times, national headquarters is hard pressed for time to devote to the additional duties concerned with the assistant program which have been superimposed on an already full schedule.

During the first year of implementation, one training program was not approved because AOTA's requirements of an acceptable training program were not met. One training program has received tentative approval.

Implementation of the program has necessitated two changes in the requirements:

1. The Board of Management, at its midyear meeting, April 6, 1959, clarified by vote the requirements for certification as an occupational therapy assistant in psychiatry under the grandfather's clause and thus liberalized its decision of October 24, 1958. The eligibility requirements in paragraph 10B, Recommendations, "Recognition of Occupational Therapy Assistants," page 269, September-October, 1958, issue of AJOT (and reprint) will be interpreted as follows:

   a. A minimum of two years work experience in the field of psychiatry under the direction or supervision of a registered OT prior to October, 1958, six continuous months of which must have been during the period from October, 1956, to October, 1958.

   b. Satisfactory recommendations from three qualified individuals, one of whom must be a registered OT.

2. Requests had been received from Texas and Illinois to change the requirement that training programs be held in hospitals approved by the Joint Commission on Hospital Accreditation. Investigation showed that this was indicated so the Board of Management, at its annual meeting on October 22, 1959, voted to liberalize sentence 2 of paragraph 1 under I "Organization of the Requirements of an Acceptable Training Program for Occupational Therapy Assistants," page 270, September-October, 1958, issue of AJOT (and reprint) and substitute, "The hospitals, to be acceptable for this training, should be staffed with properly accredited psychiatrists and properly qualified personnel in allied disciplines. It is highly desirable that there be educational programs."

An *ad hoc* committee has been formed to develop a curriculum guide which will include the commonalities of all areas with provision for emphasis on the area of particular interest. Any disease which leaves a residual, *i.e.*, chest diseases, gerontology, etcetera, will be considered. Frances E. Heess and Carolyn Aggarwal accepted the assignment and met with the committee to discuss this development.

The legislative and civil service committee is making a study of different levels of positions for occupational therapy assistants and will make recommendations to this committee for consideration.

As occupational therapy assistants are certified, they are invited to join AOTA as associate or associate subscriber members.

Respectfully submitted,
Marion W. Crampton, O.T.R.
Chairman.

CLINICAL PROCEDURES COMMITTEE

The clinical procedures committee has been in a state of reorganization since the appointment of the new chairman by President Willard in February, 1959. To date two chairmen of sub-committees have been named: Miss Lilianne Steckel for physical disabilities and Miss Naida Ackley for psychiatry.

It is noted that the sub-committees on GM&S, pediatrics, and tuberculosis were not utilized during the conference year of 1958 (per report, October, 1958) and work of the psychiatric sub-committee was not reported as of that date. The work of the administrative sub-committee, a "synthesis of treatment objectives" was reported. Two pieces of unfinished work remain: (1) a glossary of terms in the physical disabilities area and the CP study; (2) validation of formulations made at the Allenberry conference.

Due to the lag in the clinical procedures committee's functioning as a contributing body, the following letter was sent by the chairman to each state delegate:

"On Sunday, 18 October, 1959, 2 to 5 p.m., and 7 to 10 p.m., the annual meeting of the clinical procedures committee will be held at the Hotel Morrison, Chicago, in connection with the AOTA conference.

"I will appreciate your extending a special invitation to the occupational therapists of your state to attend these meetings.

"The purpose of the clinical procedures committee is defined as follows: to serve as a voice and communication center for the practicing therapist.

"I hope that those attending will make suggestions for studies relative to the clinical programs and that this committee will be able to make a contribution of value during the next year."

Hope continues that the open meetings of this committee, scheduled for Sunday, October 18, will be attended by individuals interested in revitalizing the existence of the clinical procedures committee.

Respectfully submitted,
Lottie V. Blanton, O.T.R.
Chairman

LEGISLATION AND CIVIL SERVICE COMMITTEE

During the past year the legislation and civil service committee has concerned itself primarily with: defining the title, functions and responsibilities of the committee; developing an SOP; considering the A.M.A. study on para-medical groups; compiling current salary schedules; establishing a roster of state legislation and civil service committee chairmen; planning for closer cooperation with the House of Delegates and with the state O.T. associations.

The availability of the model class specifications from the national office was announced in the AOTA *Newsletter*, December, 1958. The report on the title and responsibilities of the legislation and civil service committee was accepted by the Board at the 1958 annual meeting. Much of the material in this report was incorporated in the SOP which was accepted by the Board at the 1959 midyear meeting.

A compilation of current salary schedules was distributed to the Board at the 1958 annual meeting and amendments were included in the 1959 midyear report to the Board.

Current projects of the committee are: a continuation of compiling information on salary schedules; in cooperation with the committee on recognition of occupational therapy assistants, writing model class specifications for the positions of occupational therapy assistants and a compilation of salary schedules for the assistants. Several requests have been received by the committee for model class specifications for the position of active therapy coordinator.

The executive director has reported the follow-up of the AMA study on para-medical groups which the committee requested at the 1959 midyear meeting of the Board. This study was mentioned in the June *Newsletter* and Miss Wade will report on it at the annual meeting of the Board with a possible follow-up in AJOT at an appropriate time.

In May a report was mailed to all state committee chairmen. These chairmen were asked to keep the AOTA legislation and civil service committee currently informed of the names and addresses of the state chairmen and of any changes in salary schedules in their states. It has been impossible to reach all state chairmen with information from the legislation and civil service committee because the roster of state chairmen is still incomplete. In the past year the committee has received the names of state chairmen from five additional states. There is no listing of chairmen from Arkansas, Illinois, Kansas, Kentucky, Maryland, Nebraska, Northern New England, Oklahoma, Tennessee, Texas and Virginia. As outlined in the committee SOP, the work of the legislation and civil service committee is a two-way proposition: receiving from the states information concerning legislation and channeling this, when appropriate, to the Board of Management for action and disseminating to the state associations information which may be of value to them and to their membership. Without the complete roster of state chairmen the committee is unable to function at its maximum potential.

It is strongly urged that the four points listed in the 1959 midyear report to the Board and repeated in the May, 1959, report to the membership be re-emphasized by the Board and the House. The committee would like to request that the functions of the committee and the areas of national and state cooperation be publicized in the AOTA *Newsletter* in order that this information reach all state associations.

One of the chief problems affecting the operation of the committee is that of the scheduling the annual meeting. The committee is well aware that this problem affects other committees also but in the past three years it has not been possible for interested persons and even delegates to attend the annual meeting of the legislation and civil service committee because of conflicts with other meetings to which they were obligated. The annual meeting for 1959 is scheduled on Thursday evening, October 22nd, from 7:00 to 10:00 p.m., which is the same time the chairman of the committee meets with the Board of Management to discuss any committee problems. It is unnecessary to point out that the chairman cannot preside at the annual meeting and discuss problems with the Board of Management at the same time.

At the request of President Willard, the chairman and members have agreed to serve to the end of her term as president in 1961.

Edna Faeser, O.T.R.
Wilma Franz, O.T.R.
Ruth Grummon, O.T.R.
Winifred Kahman, O.T.R.
Virginia Caskey, O.T.R.
Chairman

REGISTRATION COMMITTEE

Membership. The registration committee currently has 11 active members, not including the education division staff, and 10 consultant members. Since September, 1958, the active members have met for a total of 17 days (10 weekends), including a 2-day meeting with the consultants in September, 1959.

June, 1959, registration examination. This examination included one new part made possible primarily by the number of items written at the Iowa City (1958) and Detroit (1959) item-writing workshops. It was administered to 310 persons at 27 approved schools of occupational therapy and at 16 other institutions of higher learning. Sixteen of these examinees finished clinical affiliations the month following the examination.

The following statistical data are presented in terms of adjusted scores (items with questionable response not scored) for regular examinees only (291):

	Part I	Part II	Total
Mean	94.51	88.5	182.5
Sigma	12.6	10.6	21.6

Correlation of Parts I and II = +.74.

Despite the introduction of an entirely new part for this examination, the data indicated the same excellent correlation as achieved in the past.

Report of performance in student affiliation (RPSA). Statistical data relative to the RPSA scores for the January and June, 1959, examinations are included below:

Date of RE	*RPSA**	*Mean*	*Sigma*
June 1955	723	145.9	37.5
Feb. 1956	732	153.5	31.9
June 1956	1104	158.4	32.3
March 1957	1106	156.3	31.7
June 1957	1167	161.0	31.2
Jan. 1958	779	163.7	27.7
June 1958	1451	166.5	28.8
Jan. 1959	663	163.4	26.9
June 1959	342	161.0	30.5

*Indicates original RPSA form

The following results were obtained from the use of the revised RPSA in January and June, 1959.

Date	*RPSA*	*Mean*	*Sigma*
Jan. 1959	236	247.1	42.1
June 1959	988	243.3	42.3

There is a difference of 92 points in the maximum score possible on the revised RPSA in contrast to the original RPSA form.

In both instances correlations were obtained for those registration examination applicants who had been rated on both evaluation forms. This was done to make possible conversions from one form to the other. The following data resulted:

Date	*RPSA*	*Revised Form*	*Original Form*
Jan. 1959	105	Mean 244.7	164.8
		Sigma 36.7	18.3
Correlation = +.17			
June 1959	228	Mean 248.5	161.2
		Sigma 30.2	28.7
Correlation = +.23			

In each instance (both the January and June, 1959, groups) the above degree of relationship required that a statistical transformation be resorted to in order to accomplish the necessary conversion from one form to the other.

In January the preponderance of original RPSA's necessitated the conversion of the revised RPSA scores to original scores. In June the numbers were reversed so that the original RPSA scores were converted to revised RPSA scores. As indicated in previous reports and as the above data show, there is still considerable "haloing" on the revised form.

Examinees under international reciprocity. Four graduates of the following schools wrote the June, 1959, examination:

Canada	University of Toronto	1
Denmark	Skolen for Beskaeftigelsesterapeuter, Hellerup	1
England	London School of Occupational Therapy	1
India	Occupational Therapy Training School, Bombay	1

Since February, 1947, 53 graduates of foreign schools have written the examination.

Revision of international reciprocity policy. The registration committee (active and consultant members) considered at length the present policy which was adopted in 1957. A proposed new policy was drawn up and the committee voted to recommend its approval by the Board of Management. Particular note was taken of the increasing number of applicants from countries where there is no formal occupational therapy curriculum available and of the need for early guidance of those foreign therapists coming to the USA to study or work and desirous of writing the AOTA examination.

Prepayment of initial registration fee. The committee voted to recommend to the Board that all applications for admission to the registration examination be accompanied by a fee of $27.00. Of this amount $15.00 would be the examination fee and $12.00 the initial registration fee. In the event that the applicant is found ineligible to write the examination, the total amount would be refunded. If he fails, he would receive a refund of $12.00. If accepted, this policy would nullify the present one which states that all persons must register *within one year* of passing the examination or re-pass it to be eligible for registration.

Eligibility for writing registration examination. Graduates of AMA-approved curriculums must complete all academic and clinical requirements (except for the *final* month of student affiliations) *prior* to writing the examination. The registration committee requests that the curriculum director ascertain that *all* academic requirements have been met before recommending the student for the examination.

It was voted that in the case of a registration examination applicant who completed clinical affiliation requirements 10 or more years prior to the date of the examination for which he is applying, and who has no occupational therapy work experience within this 10-year period, the written part of the examination be scored on the basis of 100%, thus waiving the 20% of the examination score normally allocated to the clinical and/or work report(s).

Registration examination prospectus. The registration committee is presently revising the work report form. This rating form is used primarily for "old-timers" having no clinical records and for foreign graduates working under a registered therapist.

Another new part is needed for the examination and it is hoped that a third item writing workshop may be held early in 1960. The items written at the previous workshops have proven the worth of holding such 3-4 day sessions.

The registration committee is gravely concerned over the revised RPSA form and looks forward to the joint meeting in Chicago at which time the form will be discussed.

Sincere appreciation is extended to the active and consultant members of the registration committee for their continued interest and the long hours devoted to com-

mittee responsibilities, to item writers, to the educational research consultant and to the vice-chairman of the committee for their aid in maintaining high registration standards.

Respectfully submitted,
Virginia T. Kilburn, O.T.R.
Chairman.

SPECIAL STUDIES COMMITTEE

The activities of the special studies committee for the past year have been as follows:

1. Survey of studies. The preliminary form was mailed to the membership with the AOTA *Newsletter*. Of 4900 forms sent, 365 (7.4%) were returned. Of these 210 were reported as doing studies and 110 indicated an interest in doing a study at some future date. Follow-up survey forms were sent through the state liaison chairmen to those who indicated they were doing studies. The returns have been compiled.

Problems were stated by those who returned forms. Many requested the names of others doing studies similar to theirs. Some of this need could be met by making available to state chairmen and interested individuals the compiled list of special studies.

2. Criteria for pictures submitted to the picture page of AJOT have been prepared and are ready for consideration by the editor and the liaison members of the committee. Such a set of criteria can be used as a guide to those who wish to submit pictures, to state chairmen who encourage members to send these pictures, and to those who screen them for publication.

3. Sources of funds which might be available to occupational therapists are being explored by this committee.

4. State activities reported were:

a. State chairmen sent follow-up forms to those in their states who reported they were doing studies, and then returned these to the core committee.

b. Dakota occupational therapy association: Miss Margaret Rood spoke at a research meeting and demonstrated techniques to occupational and physical therapists from the Dakotas, Minnesota and Nebraska.
New York: special studies chairmen compiled the list of studies done for masters theses at local universities to add to this year's survey of studies.

Respectfully submitted,
Patricia Holser, O.T.R.
Margaret Orchard, O.T.R.
Mary Reilly, O.T.R.
Beverly Troyer, O.T.R.
Julie Werner, O.T.R.
Chairman

RECRUITMENT AND PUBLICITY COMMITTEE

The year 1959-60 has shown an acceleration of activity and interest in recruitment. In a previous report to the membership, the regional organization of the country was described. The last of the four initial recruitment workshops was held in May in San Francisco. Four elected chairmen are now responsible for their respective regions, and are in the process of planning followup workshops. This will make current activity more widespread.

The first midyear meeting of the four chairmen was held this year and enabled us to organize a total effort for recruitment and afforded an opportunity for communication and exchange of ideas that was needed. It was at this time, too, that a first joint meeting was held with school directors and regional chairmen. This was so successful that another meeting has been scheduled. This liaison is vital for the success of recruitment.

Reports relative to enrollment in the schools have not been complete. Of those received, some have shown a marked improvement and others an alarming decrease. The recruitment committee is seriously considering a method for evaluating recruitment results, as most of our effort has been directed toward students in junior high schools, high schools and undergraduate students in the colleges. It is estimated that at least two years must elapse before any results of present activity can be estimated.

Recommendations for future planning: 1. A large potential group of recruits exists among young married women with school age children, who are seeking employment, or who want further schooling. A means of accepting and training this group should be considered. 2. It is recommended that recruitment chairmen be elected in state associations. This will add prestige to the office and function of the chairmen. 3. With the ultimate expiration of the National Foundation grant, we must look toward some means of self-support to carry on recruitment, and keep it at its present level.

Respectfully submitted,
Frances L. Shuff, O.T.R.
Chairman

RECOGNITIONS COMMITTEE

Selection of the candidate for the award of merit was made by the executive committee of AOTA from the screened list submitted for their consideration.

The committee studied and made literary and lay-out changes in the SOP under which it functions.

The chairman met with the Eleanor C. Slagle awardee in California.

Approval was granted for the printing of standard operating procedures for the committee on recognitions. The committee suggests that a description of the historical development as noted on page one be evaluated and considered as a necessary part of standard operating procedure booklets of standing committees. It is recommended that every delegate have a booklet and nomination forms reproduced on colored paper: yellow for award of merit, blue for Eleanor Clarke Slagle lectureship. Sound structure in committee over-lap is cited by the members as good operational procedure to be considered for other committees.

As noted, the terms of service end for Caroline Thompson and Florence Stattel. The new vice-president will be the new chairman and she will be responsible for the chairing of the committee and await the appointment by the president of one committee member to replace Miss Thompson.

Respectfully submitted,
Caroline Thompson, O.T.R.
Mary Britton, O.T.R.
June Sokolov, O.T.R.
Florence M. Stattel, O.T.R.
Chairman

PHYSICIANS OT REFERENCE MANUAL

The "Physician's O.T. Reference Manual," which has been in the process of compilation for almost three years, has now had its final editing and is in the hands of the publisher. Copies for distribution by the AOTA should

be available by the end of this current year, 1959. The manual contains about 150 pages. It was written and is intended as an interpreting vehicle for physicians, relative to clinical procedures and basic treatment criteria for occupational therapy and the education of occupational therapists.

Almost three years have gone into its preparation, accomplished by a professional staff of fifteen of our ablest therapists, each representing a diagnostic specialty. It has been reviewed by the AOTA medical advisory council and edited by ten OT consultants, specialists in their field of education and clinical practice. The committee numbered thirty-two, and they all should be deeply commended for the time and effort which each personally contributed. Special mention and appreciation should be extended to Wilma West, who undertook the final editing, when the chairman of this committee was overseas last year.

Respectfully submitted,
Marguerite Abbot, O.T.R.
Chairman

HISTORY COMMITTEE

Your history committee is presently sorting and filing the contents of some enormous cartons of material accumulated over many years in the national office. Just as this job seems to become dull, something interesting or downright fascinating makes its appearance. Many of these things would give you great pride in your heritage, and we do earnestly hope that somehow a history of the association can be written before long.

Some requests for specific types of early information make apparent the need for a catalog of what is extant. This is the objective toward which the committee is presently working, so we feel that in the near future you will be able to get the information or at least be referred to its source when you need or want it.

One thing the committee has learned is the importance of dates on everything. It is astounding to find so many printed programs, articles and reprints with no dates. But more than that it is heart-breaking to realize that many of these would be of great interest and value if they could be assigned to a definite year or even era in some cases. Without this possibility they are virtually worthless. The committee hopes that a "word to the wise" is sufficient.

Respectfully submitted,
Marianne Catterton, O.T.R.
Chairman

SPECIAL PROJECTS FUND COMMITTEE

The special projects fund committee has a membership comprised of representatives from each of the state and regional associations. During the year 1958-59 the following material was distributed to the membership: "Information Sheets to Be Used by Trust Companies" and an "Open Letter to the Membership and Friends of the AOTA." Several local associations have requested additional copies of the information sheet and have indicated interest in behalf of prospective contributors to the fund. The special projects fund committee's responsibility is to raise funds from interested sources or projects which will aid in the improvement of occupational therapy procedures. At present the association's finances do not allow the carrying out of the many worthwhile projects recommended by members of our own field as well as members of allied fields. It is only through such a fund that the carrying out of these projects will be realized.

A goal of $200,000 established for this fund can only be attained through the concerted efforts of each member of AOTA. Any ideas or suggestions to methods of raising this amount should be forwarded through the local chairman to the national chairman of the committee.

Respectfully submitted,
Elizabeth Collins, O.T.R.
Chairman

MANUAL ON ORGANIZATION AND ADMINISTRATION OF OCCUPATIONAL THERAPY DEPARTMENTS

During the past year our committee has met for corporate thinking during the 1958 conference and on two other occasions. We have had frequent correspondence between members and have incorporated the assistance of many other therapists in order to develop the revision of the manual.

In the revised manual we propose to discuss the three basic areas of consideration for any type or size occupational therapy department. These areas are personnel, procedures and facilities. At the present time the committee members are writing the first draft of the revision, based on a survey done with over 50 occupational therapy departments throughout the country. We shall meet again during the conference in Chicago for further corporate work on these drafts.

Members of AOTA are encouraged to send us their useful suggestions of materials to be included in the bibliography. We also need more floor plans and equipment lists of occupational therapy departments for reference purposes.

Respectfully submitted,
Mary Alice Coombs, O.T.R.
Evelyne Eichler, O.T.R.
Irene Hollis, O.T.R.
Martha Schnebly, O.T.R.
Adelaide T. Smith, O.T.R.
Viola W. Svensson, O.T.R.
Elizabeth M. Wagner, O.T.R.
Alberta D. Walker, O.T.R.
Cornelia Watson Beck, O.T.R.
Chairman

COMMITTEE ON ADMINISTRATION PRACTICES AND PERSONNEL POLICIES

This committee was appointed in the spring of 1958, and charged with the responsibility of revising and expanding the *Administration Practices and Personnel Policies* of the American Occupational Therapy Association. Since that time resource material has been gathered through various related agencies and organizations, and the first draft of the revision was drawn up for discussion of the committee during the 1958 conference in New York City. Necessary suggestions and deletions were made at that time and the committee agreed to work on further suggestions during the winter. A second draft was compiled by the chairman and submitted to committee members via mail for consideration, deletions and suggestions during the summer of 1959.

The most recent draft of the material was submitted to the Board of Management at the 1959 conference, together with the resignation of the chairman, who feels that she can no longer assume the responsibility of the committee and delay the necessary work to be done. The committee and the chairman have appreciated the opportunity of serving the association and working with the

AOTA membership in helping to further promote good administrative practices and personnel policies.

Respectfully submitted,
Evelyne Eichler, O.T.R.
Mary Alice Coombs, O.T.R.
Mary Frances Heermans, O.T.R.
Margaret Gleave, O.T.R.
Elizabeth L. Jameson, O.T.R.
Chairman

PRE-VOCATIONAL EXPLORATION

During the November, 1956, annual workshop of the conference of Rehabilitation Centers and Facilities, a number of occupational therapists who happened to be present were invited by Susan Barnes, O.T.R., to consider the role of the occupational therapist in the area of pre-vocational appraisal of patients. The interest of the group present had been heightened by the controversial opinions of participants of the conference, many of whom felt that this phase of rehabilitation should be properly delegated to the vocational (or rehabilitation) counselor and the industrial arts instructor.

A rather spirited meeting resulted in renewed affirmation of De Tocqueville's theories; a committee was formed to prepare a questionnaire which might produce statistical information with regard to the number of occupational therapists in the United States who are presently engaged in, or contemplating some role in pre-vocational evaluation within their institutions.

In due course, the questionnaire was prepared and the pro-tem committee chairman approached the American Occupational Therapy Association and the National Society for Crippled Children and Adults to consider means of duplicating and mailing. The AOTA office agreed to handle duplication, collation and mailing and the NSCCA generously agreed to assume a portion of the mailing costs in the interest of the many occupational therapists associated with Easter Seal Agencies throughout the country.

Florence Stattel, occupational therapy consultant for the NSCCA, obtained professional help from that agency and from AOTA personnel on construction of the questionnaire, and submitted it to Colonel R. Robinson, past president of the American Occupational Therapy Association, for final approval. Accompanied by an explanatory letter, 5,000 copies of the questionnaire were mailed to occupational therapists on April 1, 1957.

At the Cleveland AOTA conference, Susan Barnes, Jean Ayres and Florence Stattel reviewed a trial tabulation of returns compiled by Miss Stattel. This material appeared significant enough to warrant further study and presentation of corrected findings at the 1958 AOTA midyear meetings.

It was encouraging to note that therapists returned 821 questionnaires of which 787 had been completely enough answered to permit for accurate tabulation. The final tabulation was carried out by the Rehabilitation Center of Greater St. Louis. It revealed that a preponderance of facilities were engaged in some facet of pre-vocational exploration; that, in the majority of instances, such programs included the services of the occupational therapy department; that an overwhelming preponderance of the respondents were interested in this phase of rehabilitation; that a sizable number of therapists felt inadequately prepared to engage in pre-vocational appraisal; that a substantial majority would be interested in participating in short courses, clinical experiences and workshops which might enhance their knowledge of this service; and, finally, that an even larger majority felt that an explicit manual on pre-vocational evaluation would be useful to them.

On the basis of this information, the committee came to a number of conclusions which it embodied in the following recommendations to the American Occupational Therapy Association:

1. The findings stemming from the questionnaire should be further studied and documented; they may serve to allay existing doubts and fears with regard to the role of the occupational therapist in this aspect of patient care.

2. Information obtained from this study should be made known to the membership, the schools of occupational therapy and curriculum study project team.

3. The markedly affirmative response to the possibility of an institute on pre-vocational exploration seems to warrant further consideration. The committee felt that a manual, alone, should not be viewed as a method of meeting the membership request for information.

4. In view of a 91% response to the need for a manual, consideration of the texts currently being developed at the Institute for Crippled and Disabled, Richmond Professional Institute, Columbia University, Highland View Hospital and other places, should be reviewed to determine whether they will meet the need adequately.

5. It was further suggested that the report of the pro-tem committee on pre-vocational exploration be referred to a study committee for continued analysis and recommendations as to how the American Ocupational Therapy Association can better meet the needs that appear to be implicit in the tabulation of the questionnaire.

In the spring of 1959, Miss Helen Willard, president of the American Occupational Therapy Association, appointed a committee on pre-vocational exploration, chaired by Frances Helmig, O.T.R. The committee held its first, informal meetings at the 1959 Chicago conference. It was agreed that (1) previous information should be summarized for this report to the membership in the American Journal of Occupational Therapy and (2) that contact should be made with state divisions of vocational rehabilitation to determine their current concepts and utilization of pre-vocational appraisal. This is currently being surveyed by the new committee.

Respectfully submitted,
Frances Helmig, O.T.R.
Chairman

ADVANCED STUDY

A graduate fellowship program for the professional preparation of leadership personnel in the education of mentally retarded children is being offered by the U. S. Department of Health, Education and Welfare.

Under this program grants will be available for study in public or non-profit colleges with graduate programs for the preparation of professional personnel in the education of the mentally retarded.

The stipend for the first year is $2,000, the second year is $2,400 and for the third year is $2,800 with an additional allowance of $400 for each dependent.

For further information write to:

Exceptional Children and Youth Section
Instruction, Organization and Services Branch
Div. of State and Local School Systems
Office of Education
U. S. Dept. of Health, Education and Welfare
Washington 25, D. C.

Delegates Division

FLORIDA

Delegate-Reporter, Arlene B. Krul, O.T.R.

The Florida Occupational Therapy Association has had a year of growth, introspection and inspiration. Our dream of a Florida occupational therapy school has finally been realized with one opening this fall in Gainesville. Under the forward thinking of its director, Alice Jantzen, O.T.R., we are assured of future occupational therapists with a modern philosophy toward patient treatment.

Our three state meetings this year exemplify the versatility of interests of our association, with recruitment, a joint meeting with the Florida Physical Therapy Association on hemiplegia and "What is wrong with the American Occupational Therapy Association?" comprising our programs. The Junior League Orthopedic Center in Daytona Beach was the host for our program "Let's Recruit." A report was given from the regional recruitment pilot workshop in Virginia and was followed by a question and answer period.

A winter meeting was held at the University of Florida at Gainesville in conjunction with the Florida center of the American Physical Therapy Association. We reached a little farther north and invited the members of the Georgia Occupational Therapy Association to join us in this meeting. The directors of both the physical therapy and occupational therapy schools, Misses Barbara White and Alice Jantzen and the Dean of the College of Health Related Services, Dr. Darrell Mase, explained the philosophy and curriculum of the College. In the afternoon a panel and lectures were given on the subject of hemiplegia with the two state presidents of the Florida Occupational Therapy and Physical Therapy Associations acting as chairmen of the panels.

Our final meeting of the year was held at the Deauville Hotel on Miami Beach with its theme "A National Occupational Therapy Convention in Florida—1965?". Here we learned what the convention bureau and the community could do to aid us in our efforts to put on a national occupational therapy convention. Inspired by the midyear joint meeting of the Board of Management and the House of Delegates, the afternoon was spent in acquainting the membership with the problems of the American Occupational Association and the projected move to Chicago.

In order to build up our scholarship fund jointly sponsored by the Florida Occupational Therapy Association and the Florida Physical Therapy Association, Miss Ruth McDonald, O.T.R., made and sold occupational therapy calendars. Various departments throughout the state contributed a linoleum block print which added to the attractiveness of the calendar.

Now that our occupational therapy school is a reality, recruitment becomes a home problem and so in order to partially fulfill our obligations the staffs from Forrest Park School, Orlando; Tampa General Hospital, Tampa; and Easter Seal Rehabilitation Center of Miami participated in professional recruitment efforts for the University of Florida sponsored by Easter Seals and Nemours Foundation.

The Florida Occupational Therapy Association looks forward with eagerness to the coming year. Although there is much to be done the willingness of our members to work and rise to the occasion is heartwarming.

OFFICERS

President	Florence Walters, O.T.R.
Vice-President	Alice Jantzen, O.T.R.
Secretary	Grace Straw, O.T.R.
Treasurer	Joanne Spencer, O.T.R.
Delegate	Arlene B. Krul, O.T.R.
Alternate-Delegate	Ruth McDonald, O.T.R.

NEW YORK

Delegate-Reporter, Agnes Dick Ness, O.T.R.

The major activity of the N.Y.S.O.T.A. since its 1959 consolidation from two into one state association has centered on better intra-state organization and communication within its five districts, which are:

Niagara Frontier: Chairman Bearldean B. Burke, O.T.R.
Rochester: Arlene Palmer, O.T.R.
Central New York: Anne K. Deimel, O.T.R.
Metropolitan New York: Joseph Kramer, O.T.R.
Long Island: Elsie F. McKiernan, O.T.R.

The state has now a total membership of 323; 206 classified as active, 10 as auxiliary, and 107 as associate members. On the local district level there has been the usual operation of standing committees; whereas statewide, most of them are still in the formative stage.

In the area of scholarship awards and loans, the Metropolitan District dispensed $2,500 last year. Two $500 scholarships were realized from the income of the Wollman Fund, one $500 scholarship and $1,000 in interest free loans were given from its treasury. To enlarge the scope of its scholarship monies this district has recently established a memorial fund.

One of Niagara Frontier District's noteworthy achievements was its initiation of a film library on occupational therapy for the use of the University of Buffalo.

Of all the meetings presented within the state (after the conference), the most outstanding by far was the first all state general membership meeting held in Rochester May 8 and 9, sponsored by that district. Miss Helen Willard, O.T.R., president of the American Occupational Therapy Association, was the featured speaker for the occasion.

OFFICERS

President	Bearldean B. Burke, O.T.R.
President-Elect	Ruth L. Smiley, O.T.R.
Vice-President	Eunice M. S. Ford, O.T.R.
Secretary	Harriet J. Tiebel, O.T.R.
Treasurer	Alice R. Trei, O.T.R.
Delegate	Agnes Dick Ness, O.T.R.
Alternate Delegate	Ruth R. Nightingale, O.T.R.

TENNESSEE

Delegate-Reporter, Barbara Wallin, O.T.R.

Distance and scarcity of therapists are still proving to be exceedingly troublesome problems for the Tennessee Occupational Therapy Association. We now have a total of only 12 registered therapists representing eight occupational therapy departments in five major cities over a 600 mile distance. Each of these departments has openings for at least one additional therapist and several other hospitals are anxious to establish departments if only the therapists could be found.

In August the first meeting for occupational therapy employees in state hospitals was held at Western State Hospital. One of the sessions of the two day meeting was devoted to evaluating the occupational therapy programs in the four represented departments. With only one registered therapist in state employ at that time the need to stress the use of crafts as therapy rather than

items for sale was most evident. It is hoped that more workshops of this type can be held to further acquaint the aides with the importance of more effective occupational therapy.

Only two state association meetings can be held each year due to the 600 mile distance between the east and west parts of the state where the members are concentrated. One meeting each year is held in the central part and the other alternates between the east and the west. Efforts are being made to have at least one yearly week-end workshop in an attempt to obtain larger attendance.

The association has a new scholarship fund-raising idea. Members are now selling gummed return-address labels at the rate of 600 for $1.50. Other plans are being formulated with hopes of increasing the fund which is now available for loan to occupational therapy students from Tennessee.

Eastern State Hospital had an occupational therapy exhibit at the Tennessee Valley agricultural and industrial fair in Knoxville in September. Emphasis was placed on "curing by doing" and recruitment and informational pamphlets were distributed.

Individual members in each major city have held open house, distributed recruitment materials and given talks at high school career days in an effort to interest students in occupational therapy as a career.

OFFICERS

President	Doris Hartman, O.T.R.
Vice-President	Anna Loftus, O.T.R.
Secretary	Judith White, O.T.R.
Treasurer	Martha King, O.T.R.
Delegate	Barbara Wallin, O.T.R.
Alternate Delegate	Doris Hartman, O.T.R.

VIRGINIA

Delegate-Reporter, Donald E. Hines, O.T.R.

The most stimulating of the five meetings held in 1958-59 by the Virginia Occupational Therapy Association was the Tri-State meeting of Virginia, Washington, D. C., and Maryland at the out-patient unit of the Children's Rehabilitation Institute in Maryland. Through the use of slides and a running commentary Mrs. Mildred Howard of the United States Department of Agriculture Research Center demonstrated the principles of work simplification involved in the three new kitchens designed by the kitchen research program. There followed an exciting pre-view of the new developments in special clothing for the handicapped homemaker by Miss Clarissa Scott, clothing specialist. The afternoon session was devoted to a discussion of the relocation of the AOTA office and other questions raised at the joint meeting of the Board of Management and House of Delegates of the American Occupational Therapy Association. This was most ably presented by a panel consisting of: H. Elizabeth Messick, Arvilla Merrill, Ruth Brunyate and Lt. Colonel Myra McDaniel.

Recruitment efforts have been combined with 15 other professions in a health careers recruitment program sponsored by the Virginia Council on Health and Medical Care. Through such united planning we feel recruitment for all related professions will benefit.

Scholarships totaling $275 were awarded to two occupational therapy students at Richmond Professional Institute. Approximately $400 was added to the scholarship fund through donations, bequests, and the sale of seals and stationery. Plans are under way for additional special fund raising projects for Virginia's contribution to the 1962 congress of the World Federation of Occupational Therapists in Philadelphia.

OFFICERS

President	Mary B. Blayney, O.T.R.
Vice-President	James Shearin, O.T.R.
Recording Secretary	Eleanor Wolfe, O.T.R.
Corresponding Secretary	Carolyn Shreve, O.T.R.
Treasurer	Bette Hopkins, O.T.R.
Delegate	Donald E. Hines, O.T.R.
Alternate Delegate	Charlotte Smith, O.T.R.

Reviews

MEANING IN CRAFTS. Edward L. Mattil. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1959, 133 pp., $5.25.

The author describes crafts and their products as a record of a meaningful experience. He sees them as something which helps the creative, social, emotional, physical and aesthetic growth of children. They can easily be used in the same way for adults, as so many do not have these experiences as children. The author describes in a simple paragraph or two how to teach the procedures of a craft and stresses that technique is an individual development that grows out of a person's need to express himself. In a stimulating way, he covers the subjects of modeling, sculpturing, print making, puppets, drawing and printing, seasonal activities, papier-mache, weaving and "stitchery." All through this book one gets the feeling that therapy is inherent in each activity as he presents it. It is a book worth adding to any library.

—Ruth L. Melsheimer, O.T.R.

EXCISION OF THE GREATER MULTANGULAR BONE AS AN ADJUNCT TO MOBILIZATION OF THE THUMB. J. Leonard Goldner, M.D., and Frank W. Clippinger, M.D. *The Journal of Bone and Joint Surgery*, Vol. 41-A No. 4 (June) 1959.

The authors advocate excision of the greater multangular and a portion of the base of the first or second metacarpal or of both in cases where even soft tissue release and addition of new skin in the thumb web area fail to give adequate mobilization of the base of the thumb following direct trauma, or indirectly by injury, to muscles or nerves in the forearm.

They present photographs and charts giving data on 22 cases where results of such excision were listed as fair, good and excellent. They discuss the various indications for the operation and give the operative procedure. Indications discussed are: Limited range of motion of the thumb from degenerative arthritis, arthrosis as a result of trauma, and severe contracture at the base of the thumb resulting from direct injury or contracture secondary to adjacent injury.

—Elizabeth J. Wood, Capt. AMSC.

ORTHOPEDIC NURSING PROCEDURES. Avise Kerr, R.N. New York: Springer Publishing Company, 1959, 364 pp., $4.75.

This is a well organized reference manual in outline form emphasizing principles and aims of procedures. Starting with the initial care of the patient at the site of the injury and including descriptions of orthopedic injuries, how to use equipment, care of the patient, pre- and post-operative care, the principles of exercise, crutch walking, physiological and psychological complications, it finishes with home care instructions. It also has a section on body mechanics for nurses.

—Jane Ring Trout, O.T.R.

APPLICATION OF CLIENT-CENTERED COUNSELING TO CLINICAL TEACHING. W. Scott Gehman, Ph.D. *The Physical Therapy Review*, 30:6 (June) 1959.

This paper was presented at a conference of physical therapy supervisors at Duke University Medical Center in November, 1958. In offering an answer to the question "How can we best help the individual develop his skills and techniques to a near maximum degree?" Dr. Gehman poses another question: "How, then, can the supervisor help the student clinician discover and use means of satisfying his need for self enhancement and self-actualization?" He defines the self-actualized person as "basically a satisfied person who is performing with the full use and exploitation of talents, capacities and potentialities." He stresses the importance to the student of serenity, peace of mind, security and emotional support in the development of creativeness, originality and inventiveness.

Dr. Gehman expresses the opinion that "Many of our students, particularly those in advanced training programs, have been thwarted in their satisfaction of self realization and achievement needs because of our relatively stereotyped educational programs." To promote self-actualization in the student, Dr. Gehman advocates a relationship between supervisor and student similar to that in counseling and psychotherapy. In such a relationship, the supervisor can help the student by providing the student with the necessary experiences and physical resources, by providing an atmosphere of acceptance, and by acting as a friendly representative of the professional society which the student will eventually join.

It is Dr. Gehman's thesis that the development of more self-actualized clinicians would be facilitated by the use of principles of client-centered psychotherapy applied to the teaching or educative process.

— Martha J. Norris, O.T.R.

CONQUERING PHYSICAL HANDICAPS, proceedings of the first Pan-Pacific Rehabilitation Conference, Sydney, Australia. International Society for the Welfare of Cripples, 1958, 591 pp., $3.00.

This is a long book in which much of what was said at the conference is quoted almost verbatim. This, however, gives a great deal of the personal feeling in the conference, and the devotion and hope that those attending have for increasing efforts in their countries in rehabilitation or "habilitation." Delegates from Australia, England, the Philippines, New Zealand, Korea, the USA and other parts of the world represented medicine, speech, physical and occupational therapy, education, social work, voluntary and governmental agencies, employers and unions.

Subjects for the sessions included: The Disabled as a Community Challenge; The Way Back, the Answer to the Challenge; The Management of the Physically Disabled Child; Amputees, Braces, Aids and Prostheses; Geriatric Units; Spastic Centers; Speech Therapy in Australia and America; Centers for Rheumatic Cases; Paraplegia; Education of Physically Handicapped Children; Employing the Disabled; Industrial Nursing; and Deaf Education.

There is a wealth of material in this book to be digested by many disciplines. By reading it one gets a better picture of the problems that other health workers have and how we can better work toward their solutions. Dr. Howard A. Rusk and Miss Marjorie Fish attended this conference and we find ourselves well represented by them.

—Ruth L. Melsheimer, O.T.R.

PRIMARY TENDON REPAIRS. Alex P. Kelly, Jr., M.D. *The Journal of Bone and Joint Surgery*, Vol. 41-A No. 4 (June) 1959.

Dr. Kelly reports on a study of 706 patients with 1,018 severed tendons treated during a five year period. In the repair of extensor tendons he concludes that those done in the area of the extensor retinaculum on the back of the hand are very often rewarding if complicating injuries are not severe, but as the surgeon progresses distally into the level of the extensor complex, many surgical problems are presented. He believes that injury of the extensor tendon in these distal areas is best handled by an internal splint with Kirschner wire rather than by relying upon the absolute cooperation of the patient required when external splints are used.

In the repair of flexor tendons he discusses various cases of repair at different levels. He concludes that flexor tendons should be repaired primarily in the carpal tunnel and at the palmar level when the condition of the wound permits, but that results of repair at the palmar level are often disappointing. He believes that for flexor tendons cut within the area of the annular ligament, repair is complicated by many problems. He says, however, that results obtained warrant continuance of primary repairs of the thumb flexor when the wound is suitable. Dr. Kelly believes that in all tendon repair the success of primary repair depends upon the skill and experience of the surgeon and upon his proper evaluation of tissue reaction to trauma.

—Elizabeth J. Wood, Capt. AMSC.

THE PHASIC ACTIVITY OF THE MUSCLES OF THE LOWER EXTREMITY AND THE AFFECT OF TENDON TRANSFER. J. R. Close, M.D., and F. N. Todd, M.D. *The Journal of Bone and Joint Surgery*, Vol. 41-A, No. 2 (March) 1959.

The authors discuss the phasic activity of the various muscles in the lower extremity, classifying them as associated with either the stance or swing phases of walking. They point out that when tendon transfer in the lower extremity is contemplated the question often arises as to whether a functional transfer can be obtained if the phasic behavior of such a muscle be violated.

Examples are given of varying degrees of success to be expected in transfers of stance phase muscles to other stance phase areas and also to swing phase areas. This is followed by mention of the possibility of benefit to the patient where transfers are done although no conversion takes place in their phasic behavior.

They discuss instances where a muscle, transferred to accomplish a certain function, may serve very well in voluntary contraction but may also fail completely to make its desired contribution to the more involuntary activity of walking.

A series of plates is shown giving the results of the use of the sound motion-picture camera in conjunction with the cathode-ray oscilloscope using internal muscle electrodes. They stress the importance of these experiments in establishing a knowledge of the phasic activities of lower extremity muscles in normal people and in preoperative and postoperative paralytic patients.

They conclude that phasic transfers retain their preoperative pattern of phasic activity, are predictable, and are superior to non-phasic transfers but that in some instances non-phasic transfers can undergo phasic conversion if transferred as a separate procedure.

Mention is made of the possibility that when prompt, spontaneous conversion does take place it might possibly be attributed to the use of ancestral pathways where the muscle at one time used to serve the function which it now has in its new position.

—Elizabeth J. Wood, Capt. AMSC.

ARTHRITIS. GENERAL PRINCIPLES, PHYSICAL MEDICINE AND REHABILITATION. Edward W. Lowman, M.D., Ed. Boston: Little, Brown and Company, 1959, 292 PP., $9.50.

Much of the material in the book was originally presented in post-graduate seminars and lectures. The book is devoted to the problems of the arthritic and is intended to demonstrate the medical and other resources which may be involved in a positive, dynamic attack on this disease which has the virulence to cripple, disable and wrack with pain.

Part I is devoted to types and pathology of the disease, anatomy of the joints, clinical features, and general medical treatment. Part II pertains to the physical medicine and rehabilitation treatment of arthritis. Collaborators on the chapters on occupational therapy materials and methods of splinting and self-help devices are Rhea K. Olson, O.T.R., and Muriel Zimmerman, O.T.R. Part III also includes material on PT, orthopedic surgery, visiting nurse care, psychological aspects, social problems, vocational counseling and job placement, and voluntary health agencies, among others.

The material presented by Dr. Lowman and the twenty-five authorities from many fields is well organized and well written. The subject matter is of vital importance. The diagrams, tables, charts, and photographs are pertinent, clear and most helpful in aiding the understanding of the pathology of arthritis, and most helpful in explaining rehabilitation devices and techniques to families of patients.

—Eunice Ford, O.T.R.

If the mechanism shown in Figure 9, Page 263, "Artisan Therapy" (Dec.) is confusing, it is because the picture is upside down for which the editor is truly sorry.

A NEW COURSE

A two-week course entitled "Principles and Practice of Geriatric Rehabilitation" will be presented April 25 to May 6 by the department of physical medicine and rehabilitation, New York Medical College-Metropolitan Hospital Center. The course will offer training in the care of the elderly chronically-ill patient. A limited number of Federal scholarships are available.

For further information write:

Dr. Jerome S. Tobis, Chairman
Department of Physical Medicine and Rehabilitation
New York Medical College
1 East 105th Street
New York 29, New York

REHABILITATION COUNSELING RESEARCH REPORT AVAILABLE

The College of Education of the State University of Iowa announces the availability of a monograph, "Critical Counseling Behavior in Rehabilitation Settings" by Dr. Marceline Jaques, now at the School of Education, University of Buffalo. It reports findings obtained by using the Critical Incident technique with 404 rehabilitation counselors in 20 states. The foreword for it was written by Dr. Wendell A. Johnson. This investigation and the publication of the final report was supported, in part, by a research grant from the Office of Vocational Rehabilitation, Department of Health, Education and Welfare, Washington, D.C. Dr. Jaques was the principal investigator and Dr. John E. Muthard was the project director for the study. Counselors in the state-federal programs and other agencies or persons on OVR mailing lists will secure copies of this report directly from OVR. Copies can be obtained without cost by writing the project director at the College of Education, State University of Iowa, Iowa City, Iowa.

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum ad $4.00 for 3 lines, each additional line $1.00. (Average 56 spaces per line.) Classified display, boxed, $5.00 per column inch. Copy deadline first of each month previous to publication.

POSITIONS AVAILABLE

Wanted: qualified occupational therapists. Well equipped progressive PM&R service headed by full-time board certified physiatrist. Hospital capacity 1065 (GM&S and psychiatric). Residential area 50,000 in beautiful countryside, near large metropolitan cities. Starting salary is $4040 per annum for recent OT school graduates with no experience. To qualify for higher starting salaries of $4980 per annum or $5470 per annum professional occupational therapy experience is required. Positions are in the career civil service with annual leave, sick leave, life insurance, disability protection and liberal retirement benefits. Write: Personnel Office, Veterans Administration Hospital, Lebanon, Pennsylvania.

Staff position for director of occupational therapy in 1700 bed state mental hospital. Salary range—$6,280.00 to $7,500.00. For further information write to Superintendent, State Hospital, Jamestown, North Dakota.

O.T. III and O.T. II with 3 and 2 years experience respectively to direct program in a school and hospital for high grade defective and emotionally disturbed adolescents. 15 day vacation, 15 days sick leave, 13 holidays. Retirement plan and Social Security. For details write Box 40, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee, Wis.

OCCUPATIONAL THERAPISTS for California's progressive programs in State mental hospitals and for physically handicapped children in special schools. Opportunities for imaginative and resourceful therapeutic activities. Eligibility for registration with the National Registry of the American Occupational Therapy Association is required. No experience is needed to start at $415 a month. Positions in schools under the Crippled Children Services program are open also to experienced occupational therapists at $458 a month. Attractive employee benefits. Secure details from State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Occupational therapist wanted for full time position in accredited psychiatric hospital. Salary based on experience, minimum $4200.00 annually. Mrs. Heide F. Bernard, Executive Director, Hall-Brooke Hospital, Greens Farms (Westport—1 hour from New York by train or car), Connecticut.

Modern well-equipped department in state hospital near Morristown, New Jersey, 30 miles from NYC. Staff positions available at $4,309 to $5,599. Opportunity for professional growth. Programs include clinics and pre-vocational areas. Lucille Boss, O.T.R., director. Civil service benefits. Low cost maintenance usually available. Apply Richard E. Winans, Personnel Director, New Jersey State Hospital, Greystone Park, New Jersey.

Wanted: Registered occupational therapist II (director), salary $4,472 to $5,564, depending on qualifications. Relatively new department with growth possibilities. Paid vacation, sick leave, legal holidays, excellent retirement system, group life insurance. Apply: Peter W. Bowman, M.D., Supt., Pineland Hosp. & Training Center, Box C, Pownal, Maine.

Registered occupational therapist II—supervisory position. Planning and directing program for 2,500 bed mental hospital. Salary range $4,452-$5,460. Three weeks paid vacation. Two weeks sick leave, legal holidays. Social security and retirement system. Group life insurance. Situated in capital city with excellent cultural and recreational facilities. Write for details and application to Mr. E. H. Tilley, Personnel Officer, Dorothea Dix Hospital, Raleigh, North Carolina.

Openings for two staff occupational therapists, registered, or eligible for registration. Opportunity to work in one of country's finest cerebral palsy clinics under experienced superior. Advantages of correlation with interesting research. Salary commensurate with education and experience. Fringe benefits, Blue Cross, Blue Shield health insurance, retirement and social security plan. Contact—Personnel Director, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Two staff positions for registered occupational therapists due to expanding program in the geriatric and the tuberculosis services. Paid vacation and sick leave; 13 holidays a year; 37½ hour week; starting salary $3828 with annual increases to $4620. Write Director of Personnel, Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore 24, Maryland.

Registered occupational therapist (career civil service) wanted, 520-bed general medicine and surgery hospital with bed allocation for TB and NP services, affiliated with Vanderbilt Medical School. Write: Manager, Veterans Administration Hospital, Nashville, Tennessee.

Occupational therapists: two openings for staff therapists at Koch Hospital, a tuberculosis hospital under the City of St. Louis. Pay range is $346 to $421 per month. Three weeks vacation. Eleven paid holidays. Other staff therapist vacancies at City, Chronic, and Homer Phillips Hospitals. For further information write to Department of Personnel, City of St. Louis, 235 Municipal Courts Building, St. Louis 3, Missouri.

Immediate opening for an OTR in an out-patient rehabilitation center. Work with children and adults with physical disabilities. New building, well equipped departments, work as a team with a physician, physical therapist, speech therapist, and psychologist-social worker. Good salary, ten paid holidays, four weeks paid vacation. If interested contact Miss Dorothy Gillman, Executive Director, The Rehabilitation Center, 702 Williams Street, Elkhart, Indiana.

Staff occupational therapist opportunities in psychiatric or rehabilitation areas. Excellent chance for advancement. Competent supervision, professional staff and assistants. Both in and out patient work. 40 hour week, vacations, sick leave, holidays, insurance, other benefits. Attractive industrial city of 200,000 with cultural and recreational advantages. Inquire Personnel Department, Iowa Methodist Hospital, Des Moines, Iowa.

Immediate openings for occupational therapists, registered or eligible for registration, in 800 bed chronic disease hospital. Active program, now being reorganized, on wards and rehabilitation services. Five day week, 3 week vacation, 9 holidays, 12 sick days; free lunch and laundry. Salary $4250-5400, depending on experience. Contact Dolores Paul, OTR, Chief, OT Dept., Jewish Chronic Disease Hospital, 86 E. 49th St., Brooklyn 3, N. Y.

Wanted: Qualified occupational therapist for out-patient cerebral palsy clinic. Five day week, six weeks paid vacation. Salary commensurate with experience. Write Dr. F. B. Kilgore, Ritter Building, Huntington, West Virginia.

Help wanted—male or female: Occupational therapist for medically supervised geriatric rehabilitation program. Start $4420 increases to $4960 in two years. Liberal personnel policies. Maintenance available. 5 day, 40 hour week. Must be graduate of accredited school. Contact Westchester County Home, 25 Bradhurst Ave., Hawthorne, N. Y. LYric 2-8300.

Immediate opening for director of occupational therapy and staff therapist in 3,000 bed state mental hospital. Salary range—director, $4,920-6,240; staff therapist, $3,600-4,080. For further information write to the Personnel Director, Central State Hospital, Norman, Oklahoma.

OT—AOTA reg. for rehab. team, service given to physically handicapped in home and hospital. Physiatric supervision, 2-yr. demonstration program. Queens area. Salary $5,000. Ann P. Kent, M.D.—HI. 6-3570, Dist. Health Officer, 34-33 Junction Blvd., Jackson Heights 72, N. Y.

Immediate opening for registered occupational therapist in the 60 bed psychiatric unit of the Cincinnati General Hospital; OT program is already well developed and closely integrated with other treatment programs; opportunity for education and professional growth in a large, dynamic resident training center; faculty appointment in Medical College; salary range $5,103 to $5,502; 2 to 4 weeks vacation. For further information contact Dr. Charles Hofling, Department of Psychiatry, Cincinnati General Hospital, Cincinnati, Ohio.

Registered occupational therapist for staff position in new, modern hospital-school for handicapped children in city of 70,000. Case load of cerebral palsy, polio and other orthopedic disabilities. Expert medical supervision and coordinated program. Beginning salary $4,050 with liberal allowance for experience. Three 3-week vacations with pay. Liberal personnel policies. Excellent opportunities for advancement, education and research. Write or call Keith Newcomb, Ass't. Dir., Crippled Children's Hospital-School, Sioux Falls, South Dakota.

Career opportunities for registered occupational therapists: senior occupational therapist $4,750-$6,178; occupational therapist $4,309-$5,599. Treatment program with acute psychiatric patients, civil service benefits; location near Princeton—accessible to New York and Philadelphia; reasonable maintenance if desired. Apply: Harold E. Miller, Personnel Director, N. J. Neuro-Psychiatric Institute, Box 1,000, Princeton, New Jersey.

Occupational therapy director wanted for medical school psychiatric department. 132 diversified in-patient beds in a dynamically oriented setting with an extensive teaching and training program. OT students planned as part of the development of an intensive OT program. Salary open. Contact Dr. Lester Schwartz, Department of Psychiatry, Albert Einstein College of Medicine, Bronx Municipal Hospital Center, Pelham Parkway and Eastchester Road, New York 61, N. Y.

Registered occupational therapist to direct OT department in 40-bed children's rehabilitation hospital. Salary depends upon experience and will range from $4,800-$5,200. Ask for a copy of excellent personnel policies when writing to Gene Clark, Administrator, Junior League Home, Nashville 4, Tennessee.

Immediate openings for one staff occupational therapist and two female staff recreational therapists in progressive psychiatric center associated with University of Michigan Medical School. Four units for intensive treatment of children, adolescents and adults, with occupational and recreational therapy supervisors on each unit. Occupational therapist is needed in children's unit and two recreational therapists on adult and adolescent units. Student affiliation center. Generous personnel benefits; salary commensurate with experience. Address communications to Personnel Department, University of Michigan Medical Center, Ann Arbor, Michigan.

Director of occupational therapy in 1,800 bed psychiatric hospital. Salary range $5,529-$7,055. Beginning salary dependent on experience. Liberal fringe benefits. Contact: Milton J. Fisher, Patient Activities Coordinator, Allentown State Hospital, Allentown, Pennsylvania.

Wanted—OTR—no experience necessary—small acute psychiatric unit. Beginning salary $4,020 with fringe benefits. Contact Rose Marie Wells, Director, Occupational Therapy, University of Texas Medical Branch Hospitals, Galveston, Texas.

Registered occupational therapist wanted: 2,000 bed psychiatric veterans' hospital, Lyons, N. J. (near Plainfield, N. J.). Career civil service; liberal benefits; salary $4,980 to $5,880. Chance for advancement. Write: Personnel, VA Hospital, Lyons, New Jersey.

Occupational therapists required by Veterans Administration hospital. Salary ranges: Non-supervisory, GS-5—$4,040 to $4,940 per annum; Supervisory, GS-7—$4,980 to $5,880 per annum; Supervisory, GS-9—$5,985 to $6,885 per annum. General information: immediate openings for occupational therapists with Veterans Administration neuropsychiatric hospital. Positions are in the career civil service. Hospital located in southeastern Pennsylvania, accessible to New York and Philadelphia. Retirement plan. Liberal sick and annual leave. Opportunities for advancement. If desired, bachelor quarters available at low cost. Applications: for forms and further information call, write, or visit VA Hospital, Coatesville, Penn., Phone: 2380, Ext. 206.

Immediate openings for two staff occupational therapists in active rehabilitation program in large psychiatric hospital. Student affiliation center, well equipped clinics, trained male assistants to help each therapist, and staff participation in medical teams. Recent graduates start at $4,040 per annum; experienced therapists at $4,980 or more. Positions are in career civil service with all benefits. Louise McMillen, O.T.R., Chief, Occupational Therapy Section. Write: Personnel Office, Veterans Administration Hospital, Waco, Texas.

Registered occupational therapist needed immediately as assistant to director in 100 bed hospital and research center for arthritis and rheumatic diseases. No experience required. Apply: Miss Betty Robinson, O.T.R., Director of Occupational Therapy, Robert B. Brigham Hospital, 125 Parker Hill Avenue, Boston, Mass.

Ideal position for ski-minded occupational therapist. Work at S. L. Co. Gen. Hosp. as staff therapist; ski at well known resorts ½-hour's drive from city. Vacation and sick leave benefits, 5-day wk., $4,200/yr. Contact Dr. J. P. Kesler, S. L. Co. Gen. Hosp., Salt Lake City, Utah.

Immediate opening for OTR with minimum of five years experience in physical disability area and demonstrated ability in developing both treatment programs and staff personnel. Position: assistant supervisor of occupational therapy in a poliomyelitis respiratory center expanding its program to serve other patients with severe, multiple disabilities. Salary open. Contact Mrs. Irene Greer Robertson, O.T.R., Supervisor Occupational Therapy, Texas Institute for Rehabilitation and Research, Box 20095 Braeswood Station, Houston 25, Texas.

Registered occupational therapists: positions available in large AMA accredited mental hospital for sr. occupational therapists. Salary range: $4,750-$6,178 annual, increment $238; or staff occupational therapists $4,309-$5,599, $215. Well OT oriented administration, OT clinical training program projected. Must be college graduate and registered or eligible for registration. Forty hour week, paid vacation, holidays and sick leave. Low cost maintenance available. If interested, please contact John E. Ellingham, Personnel Director, Ancora State Hospital, Hammontown, N. J.

The newly opened Illinois State Psychiatric Institute needs several registered occupational therapists, with or without experience to develop its intensive treatment, training and research program for four hundred patients. Salary range from $4,020-$6,060, depending on experience. Write: Mrs. Carolyn Owen, O.T.R., Supervising Therapist, Illinois State Psychiatric Institute, 1601 West Taylor St., Chicago, Illinois.

Staff therapists are wanted for chronic disease (all ages and geriatric program in a 2000 bed hospital and home affiliated with New York Medical College. Positions are available in children's rehabilitation (cerebral palsy), adult rehabilitation, and hospital-home maintenance program. Student training will begin in 1960. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit, six hour day for three summer months. Salary $4250. Write Mrs. Carolyn Aggarwal, O.T.R., Bird S. Coler Hospital and Home, Welfare Island, New York 17, New York.

OTR to head OT department in large, modern tuberculosis hospital in suburban Cleveland. Near excellent transportation, recreational and shopping facilities. Paid vacation and holidays, liberal sick leave cumulative to 90 days, retirement plan, 40-hour week. Full maintenance available at $40 monthly, including garage and laundry. Write: Director of Rehabilitation, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered therapist wanted; full rehabilitation program; geriatric home and hospital, 450 beds; $5,000 per; 3 weeks annual vacation; write Frances Schervier Home and Hospital, 2975 Independence Avenue, New York 63, N. Y.; Attn: Mrs. E. Sullivan, O.T.R.

Rehabilitation service of large teaching hospital has openings for: chief occupational therapist, staff occupational therapist. Occupational therapy department has active and progressive programs in clinic, ward, rehabilitation and psychiatric divisions stressing functional therapy, ADL training and home making activities. Student training program, both in and out patients, throughout the year. Starting salary based on experience and training. Apply to Arthur L. Watkins, M.D., Chief of Physical Medicine, Massachusetts General Hospital, Fruit Street, Boston, Massachusetts.

Director of OT; 300 bed psychiatric hospital; Racine, Wis. Salary: $4,956. Interested administration; exc. cooperation; opp. to effect new therapeutic ideas. Contact: Patricia Thornton, O.T.R., OT Consultant, Division of Mental Hygiene, 1552 Univ. Ave., Madison, Wis.

Occupational therapists—$410-$446 monthly, 40 hour week. Immediate positions with medical and psychiatric patients in 6,000 bed hospital in metropolitan Detroit. Up to three weeks vacation after one year. Citizenship and OT degree required, OT certificate preferred. Write: Wayne County Civil Service Commission, 628 City-County Building, Detroit 26, Michigan.

Position available immediately for O.T.R. Director of patient services in 80 bed tuberculosis hospital. Salary dependent upon experience. Maintenance if desired, at nominal fee. Apply to Dr. George H. Phillips, Medical Director, Jackson County Sanatorium, Jackson, Michigan.

Staff positions available for registered OT's. Department of OT, Indiana University Medical Center. Openings exist in the following areas: pediatrics (195 bed and large out patient service); adult GM&S and rehabilitation (272 bed and out patient service); cerebral palsy clinic (annual case load 776 patients). This department maintains a regular student clinical training program, and the clinical OT services are closely integrated with the undergraduate curriculum in OT at Indiana University. Annual salary is from $4,000, adjusted according to experience. Applications should be directed Patricia Laurencelle, O.T.R., Director, Department of Occupational Therapy, Indiana University Medical Center, Indianapolis 7, Indiana.

Opening for registered occupational therapist in interesting rehabilitation center. In and out patient center for wide variety of disabilities covering all ages. Excellent medical supervision. Functional program includes muscle re-education, ADL, evaluation of need and use of adapted equipment, wheelchairs, assistive devices, and vocational assessment. Fringe benefits include Blue Cross, Blue Shield, life insurance, social security, short training courses as indicated, 3-week paid vacation and sick leave. Salary commensurate with experience. Contact: Administrator or Jean Godfrey, Chief O.T., Institute of Physical Medicine and Rehabilitation, 619 N. E. Glen Oak Avenue, Peoria, Illinois.

Occupational therapists: $4,590-$5,273 annually (depending on experience and qualifications). Vacancies at Milw. Co. Insts., Wauwatosa, suburb of Milw. 40-hr. work wk. Accred. degree in OT; elig. for regist. by Amer. O.T. Assn.; sound annuity, pension & soc. sec. benefits; liberal holiday, vacation & sick allow. Apply: Milwaukee County Civil Service Commission, Room 206, Courthouse, Milwaukee 3, Wis.

Occupational therapist, for Ventura County General Hospital. Requires eligibility for national registry. Salary starts at $348. Apply: Mahlon Turner, Personnel Director, County Office Bldg., Ventura, California.

Supervisory position available, pediatric service, for experienced OT, Department of Occupational Therapy, Indiana University Medical Center. The Riley Memorial Hospital (195 bed and large out patient service) OT service was founded in 1924, and today is a substantial and well-recognized part of the medical center. This position requires the support and direction of the present program, the development of new programming and services, the supervision of staff therapists, and of students assigned in the regular clinical training program of the department. In addition there is a close integration of this service with the undergraduate program in OT at Indiana University. Support for research undertakings is also available. Annual salary from $4,800, adjusted according to experience. Inquiries should be addressed to Patricia Laurencelle, O.T.R., Director, Department of Occupational Therapy, Indiana University Medical Center, Indianapolis 7, Indiana.

Occupational therapist in private psychiatric hospital (O.T.R.). Work includes recreation and entertainment as well as the occupational therapy program for both men and women. Maintenance is provided. Salary open. Apply to Clifford D. Moore, M.D., Medical Director, Stamford Hall, Stamford, Connecticut.

Position available for staff therapist in psychiatric clinic of university hospital. Write: Mrs. Mary K. Bailey, Chief, Occupational Therapy Department, The Johns Hopkins Hospital, Baltimore 5, Md.

Northern Wyoming—immediate opening in new rehabilitation center. Salary $4,224 for 1 yr. experience with increase of $192 for each additional year. Two weeks vacation plus 1 professional meeting and 1 educational course yearly. Major medical plan. Challenging position for OTR with pioneer spirit in treatment media, organization and public education. Contact Patricia Kelsey, OTR, Gottsche Rehabilitation Center, Thermopolis, Wyoming.

Staff position available in 500-bed teaching hospital for registered occupational therapist. Areas included are psychiatry, pediatrics and physical disabilities. Occupational therapy study program. Pleasant working conditions. University community. Contact: Personnel Office, University of Virginia, 1416 West Main Street, Charlottesville, Virginia.

Staff position with a future: where experimental programs and projects are under way, where we have combined therapy groups with OT and psychologists working together as co-therapists, where professional growth and progress is encouraged. William N. Starnes Jr., O.T.R., Wernersville State Hospital, Wernersville, Pennsylvania.

Supervising occupational therapist and staff occupational therapist for the University of Virginia Children's Rehabilitation Center. 30 bed multi-disability in-patient unit plus out-patient case load. Treatment, by prescription, of functional nature. Experience in physical disabilities preferred. College community beautifully situated in the foothills of the Blue Ridge mountains. Security benefits. Pleasant working conditions and congenial associates. Contact Personnel Office, University of Virginia, 1416 West Main St., Charlottesville, Virginia.

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Button-Aides, produced by Button-King and distributed by Fascole Corporation are fine button aids for the handicapped. The Aide comes with a regular handle, knob handle and large, built-up handle. Recently a Button-Aide for amputees has also been introduced. They come with a wood handle which fits all hooks and with a suction base. These devices have been designed and produced by occupational therapists and are a valuable adjunct in ADL (Activities of Daily Living) training.

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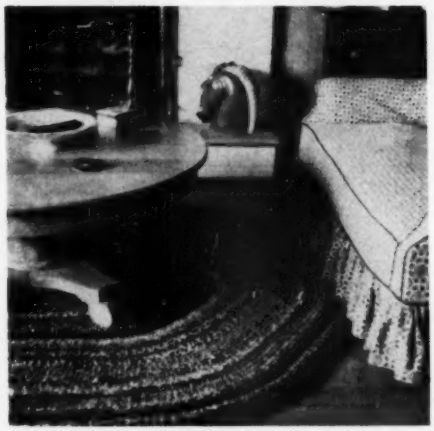

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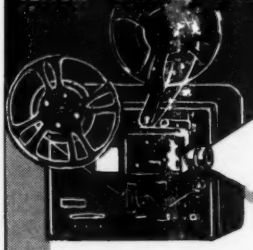

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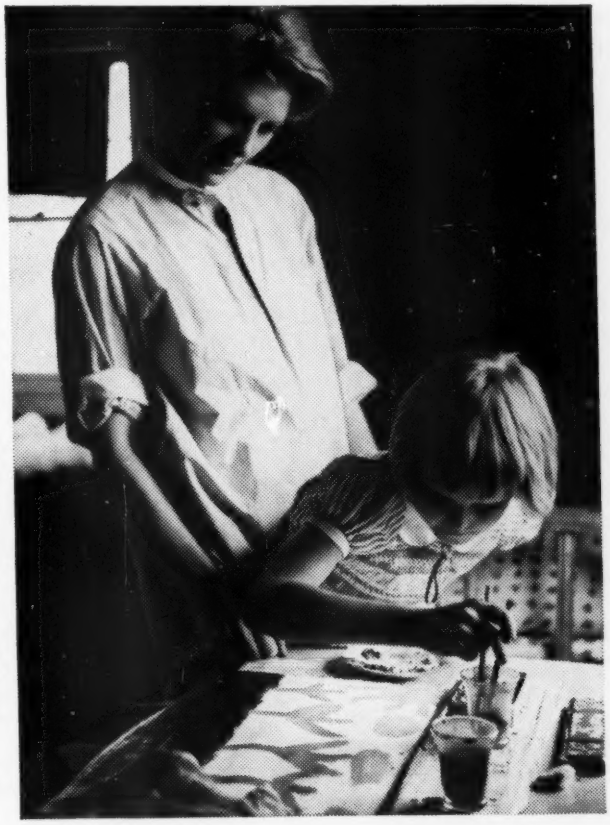

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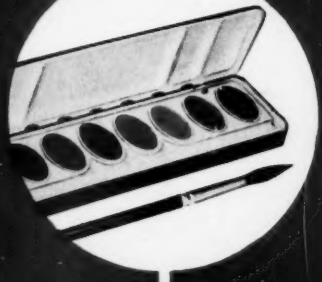

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